American Medical Rehabilitation Providers Association

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The Honorable Max Baucus
Chairman
Senate Finance Committee
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The Honorable Dave Camp
Chairman
House Ways and Means Committee
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The Honorable Orrin Hatch
Ranking Member
Senate Finance Committee
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The Honorable Sander Levin
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Via Email: postacutecarereform@mail.house.gov and postacutecarereform@finance.senate.gov

Dear Chairman Baucus, Chairman Camp, Ranking Member Hatch, and Ranking Member Levin:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), thank you for the opportunity to comment on options to reform the Medicare post-acute care (PAC) system. AMRPA agrees that positive, thoughtful delivery system and payment reforms must be made to post-acute care. Such changes must embrace real delivery system reforms that are focused on the patient. Unfortunately, many past proposals to change the post-acute care system have not been reforms, but rather cuts to the payment system that do little to improve patient care. We look forward to working with the Committee to strengthen post-acute care to ensure patients have access to medically-necessary, inpatient and outpatient rehabilitation care.

AMRPA is the national trade association representing inpatient rehabilitation hospitals and units (IRH/Us), outpatient rehabilitation centers, and other medical rehabilitation providers. AMRPA members provide medical rehabilitation services in a vast array of health care settings, including IRH/Us, hospital outpatient departments, and settings that are independent of the hospital, such as comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and outpatient practices in skilled nursing facilities (SNFs). AMRPA members work with patients to maximize their health, functional skills, independence, and participation in society so they are able to return to home, work, or an active retirement.

AMRPA's comments focus on four main areas: (1) Section I provides historical perspective on the development of the current post-acute care system; (2) Section II includes several fundamental principles that Congress should consider when undertaking post-acute care reform; (3) Section III discusses several current proposals that would harm rehabilitation patient care by imposing damaging cuts to IRH/U providers and services in response to the Committees' request for comment on Table #2 in the Joint Committee document; and (4) Section IV includes a detailed discussion with respect to the Continuing Care Hospital, an alternative delivery and payment model already authorized by Congress that remains untested by the Centers for Medicare and Medicaid Services (CMS). Additionally, Section V responds to specific questions posed by the Committee,

I. Rehabilitation Hospitals Provide Critically-Important Care to Individuals Working to Overcome Challenging Disabilities from Injuries, Illnesses and Conditions

Medical rehabilitation is a critical component of the health care delivery system. AMRPA members work daily with Medicare and Medicaid beneficiaries to maximize their health, functional skills, independence, and participation in society so they are able to return to home, work, or an active retirement. AMRPA members provide rehabilitation to patients working to overcome some of the most challenging injuries and conditions known, including brain injury, spinal cord injury, musculoskeletal injuries and diseases, stroke, and other neuromuscular problems. Medical rehabilitation prevents unnecessary medical costs in the long-term and allows patients to return to the most important people and activities in their lives.

Members of Congress are familiar with the quality medical care that patients receive in IRH/Us. Rehabilitation hospitals have provided essential and effective care for the spouses, parents, sons, daughters, and other family members of Members of Congress. Congress, along with the rest of the country, has also watched with admiration as Senator Mark Kirk (R-IL) and former Representative Gabrielle Giffords (D-AZ) have recovered from devastating injuries and medical conditions by receiving intensive medical rehabilitation services. With courage and fortitude, these individuals have relearned how to walk, speak, read, and write through hospital-level rehabilitation care.

Unfortunately, there is occasional confusion regarding the critical role of IRH/Us within the post-acute care spectrum, which stems from a more general concern about the numerous provider types offering post-acute care services to beneficiaries. With increasing pressure on the funding for this care, and the growing numbers of providers competing to offer these services, it is not surprising if some policymakers perceive the current post-acute care market as chaotic, confusing, costly, and less than clinically optimal.

In many ways, the emergence of post-acute care is a story of success. The medical community has been terrifically successful at eradicating fatal diseases and injuries and turning most fatal conditions into chronic conditions. While this is undoubtedly good news, these dynamics have dramatically increased both health and longevity, thus creating the need for ongoing post-acute care as well as chronic care management. The medical rehabilitation field was developed early in 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.

In 1982, Congress passed the Tax Equity and Fiscal Responsibility Act, which established target ceiling limitations on payments for all hospitals. Congress later passed the Social Security Disability Amendments of 1983, which established the inpatient prospective payment system (IPPS) utilizing diagnosis related

groups (DRGs) as the classification system used for payment for acute care hospitals. Certain providers were excluded from DRG payments, including rehabilitation hospitals and units. At that time, the number of post-acute care providers was quite small. The predecessor organization to AMRPA completed a survey of rehabilitation hospital and units in 1984 and found that there were 308 rehabilitation units and 49 rehabilitation hospitals.

In reaction to the IPPS, many acute care hospitals responded to the various incentives it contained by discharging patients more quickly and with greater medical complexity. In reaction to the number of patients who needed care subsequent to their acute care stay, the number of rehabilitation providers began to grow in order to treat the patients needing medical rehabilitation services. The field reached the largest number of IRH/Us in 2005 with 1,235 IRH/Us; since that time, the field has shrunk each year to 1,161 in reaction to various policies promulgated by CMS.[1] In contrast, other post-acute care providers have experienced a trajectory of continued significant growth. In 1986 there were 93 long-term care hospitals (LTCHs), 9,026 SNFs, and 6,236 home health agencies (HHAs), according to CMS. In 2013, these numbers were 436 LTCHs, 15,685 SNFs, and 12,384 HHAs.[2]

With the passage of the Balanced Budget Act of 1997 (BBA), Congress sought to arrest post-acute growth by also phasing in a prospective payment system (PPS) for each post-acute venue starting with HHAs and SNFs and, later, IRH/Us and LTCHs. BBA had varying degrees of impact on limiting post-acute growth. The number of HHAs actually declined considerably before increasing again. SNFs also grew; LTCHs became the fastest growing post-acute segment in the post-BBA era. With the advent of the multiple PPSs established by the BBA, each provider type gained further identity. These identities included separate regulations, requirements, payment systems, and patient assessment instruments.

While there are a number of post-acute care provider types, IRH/Us are separate and distinct from all of them, both in terms of regulatory requirements and quality of care provided. Currently, rehabilitation hospitals and units must meet numerous regulations, which are more extensive than those applicable to any other post-acute care provider. In order to be considered an IRH/U, the provider must satisfy the classification criteria found at 42 C.F.R.§412.29. These criteria require extensive pre-admission screening of patients, a treatment plan for each patient, a coordinated multidisciplinary team approach, and other requirements. These criteria also include the 60% Rule discussed in more depth below, which limits the types of patients IRH/Us can accept.

Medicare requirements for IRH/Us are stringent and different from other post-acute care providers. To be classified as an IRH/U, the hospital must have medical directors and nurses who specialize in rehabilitation, have 60 percent of admissions come from 13 specific categories, and can only admit patients who can tolerate and need 3 hours of inter-disciplinary therapy a day, and have the potential to meet predetermined goals.

Additionally, each patient treated in an IRU/U must meet strict medical necessity coverage criteria. IRH/Us are required to provide: close medical supervision by a physician with specialized training; 24-hour rehabilitation nursing; a multidisciplinary team approach; and three hours of intensive therapy daily.[3] Other post-acute care providers are not required to provide any of these critical services, nor do so with the same frequency, intensity, or professional sophistication. IRH/Us treat a select set of patients who need intensive rehabilitation that cannot be provided in any other setting. AMRPA urges Congress to remember the unique role of inpatient medical rehabilitation as it considers post-acute care reform.

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[1] Centers for Medicare & Medicaid Services OSCAR Report, March 2012.
[2] As of April 2013, CMS.
[3] 42 C.F.R.§412.622.

II. AMRPA Recommends that Congress Adopt Several Fundamental Principles when Reforming Post-Acute Care

As noted, AMRPA supports reforms to the post-acute care delivery and payment systems provided that the reform follows several fundamental criteria. In order to advance post-acute care reform, AMRPA developed a number of principles for reform that will help ensure that a new delivery and payment system is feasible for providers and beneficial for patients. Specifically, AMRPA requests that Congress incorporate the following principles as it seeks to reform post-acute care:

- While reforming post-acute care, Congress should take steps to reduce the need for post-acute care in the first instance. As a nation, we have a vast amount of knowledge in treating the predominant diagnoses for post-acute care, including stroke, spinal cord injury, congestive heart failure, chronic obstructive pulmonary disease, traumatic brain injury, and wounds. At the same time, we know of ways to prevent them or mitigate their effects. For example, certain drugs can greatly mitigate the adverse effects of stroke or spinal cord injury if administered in a timely manner. Many brain injuries can also be prevented with appropriate protection of the head during sports. Additionally, lifestyle changes such as diet, exercise, and smoking cessation also prevent the chronic conditions being seen and treated by IRH/Us. Congress should encourage policies that prevent the need for acute and post-acute care as a fundamental step to reducing costs and improving outcomes.

- The special needs of vulnerable populations must be addressed in the reformed system. We are specifically concerned about the unique needs of persons with disabilities, persons with multiple chronic conditions, and patients who have the potential to resume prior activities if they receive adequate rehabilitation care.

- Clinical decision making—both with respect to the type and site of care—should determine patient care. Clinicians should be empowered to make post-acute care utilization decisions with reasonable criteria that are evidence- and consensus-based. Periodic audits could be utilized to hold physicians accountable to exercising that authority.

- Post-acute care reforms should be focused on improving the delivery system rather than simply driving down payment. Several current proposals are designed to garner savings without an understanding of their impact. There are already several "blunt" instruments in place which are having dire effects on beneficiary care, such as the therapy caps.

- Post-acute care reform should include an accurate definition of post-acute care. The current definition excludes outpatient services and is being driven by how Medicare Parts A and B are defined, not by how care is actually delivered. Post-acute care reform and reinvention will only be successful by eliminating this arbitrary divide.

- A reformed system should ensure electronic interoperability between and among different providers of care. Post-acute care providers are at the crossroads of information flowing out of the acute care hospitals, yet post-acute care providers were not included in recent health information technology (HIT) incentive programs. The absence of such funding for post-acute care providers has arguably made information sharing worse than before the incentives were provided. Post-acute care providers should be included in HIT incentives to enhance patient care and reduce costs.

- A reformed system should create a mechanism to promote frank and open discussion between acute care hospitals and post-acute care providers to identify and rectify adverse health outcomes that occur because of care transitions.

- Any reform of the post-acute care system should include consideration of repeal of the therapy caps or, at the very least, extension of the therapy caps exceptions process. The therapy caps are an arbitrary financial limitation imposed annually on Medicare beneficiaries in an effort to control spending for therapy services. Unfortunately, the sickest Medicare beneficiaries, those with disabilities or multiple chronic conditions, are often the types of patients who need therapy services but are the most negatively impacted by this limitation.

- Congress and the Department of Health and Human Services (HHS) should be aware that changes to Medicare payment systems are often also adopted by private insurers and State Medicaid programs. As a result, Congress should consider the implications of any changes to the Medicare payment system on the non-elderly population, especially young people. At the very least, HHS should clearly articulate that Medicare payment systems are meant to apply primarily to elderly patients (65 years and older) covered by Medicare.

- All stakeholders, including health care professionals and patients, should be consulted in the development of a new Medicare physician payment system.

- Patients must be incentivized to utilize the right services at the right time. Cost-sharing should be structured to avoid patient over-utilization of services or the expectation of certain types of care under any circumstance.

- The current post-acute care system, including provider fee schedules and coverage criteria, is well-established. Therefore, any changes to this system will require extensive provider, professional, and patient outreach and education. As a result, implementation of a reformed system should include a sufficient transition period and resources for such education.

- Reformed post-acute care systems should include metrics related to quality of care that are granular enough to accurately assess the impact of policy changes on patient outcomes, patient access, and patient choice, as critical components of the system. Quality measures selected for any reformed post-acute care system should be based on the principles of:

    - Avoiding adverse events;
    - Achieving positive health outcomes;
    - Achieving positive functional gains;
    - Providing a positive patient experience;
    - Achieving durable health and functional gains; and
    - Demonstrating efficient and cost effective use of resources.

- Payments must reflect the true cost of care and resources utilized based on the patient's conditions. Systems that allow for a fixed number of visits or an average cost limit disproportionally penalize patients with complex disabilities such as spinal cord injuries, brain injuries, and some neurological conditions that require extended rehabilitation.

- Provider regulatory and administrative burdens should be minimized whenever possible. Current regulations that inhibit the use of the most cost effective setting—such as the 3-hour rule, the 3-

day hospital stay rule, and the 25% Rule—should be eliminated and replaced with incentives to use post-acute care settings prudently.

- The payment eligibility criteria for post-acute care providers should be reformed based on structure, process, and outcomes for each setting, and these criteria should not be confused with defining appropriateness for treatment for a specific patient.

These principles will help to ensure patient access to high quality rehabilitation care. If incorporated into a revised post-acute care delivery and payment system, these principles will ensure patients receive the care they need to achieve positive outcomes.

III. Congress Should Avoid Market Basket Cuts, Site Neutral Payment, and the 75% Rule, which will Harm Patient Care without Improving the Delivery System

The Committees' request for comments summarizes various payment system "reform" proposals—including market basket cuts, site neutral payments, and the 75% Rule—put forward, in whole or in part, by a number of interest groups, the President, the Medicare Payment Advisory Commission (MedPAC) and the Simpson-Bowles Commission. These proposals do not represent reform, but rather payment cuts and redistributional efforts that will ultimately harm patients. The proposals do not take into account the needs of rehabilitation patients, the changing nature of the health care delivery system, and the clinical judgment of expert physicians. To ensure continued access to high quality, medically-necessary inpatient rehabilitative care, Congress should reject these proposed payment reductions to IRH/Us.

A. Congress Should Avoid Further Cuts to IRH/Us, a Sector that has been Cut Significantly and in which Growth Concerns are Minimal

Proposals under discussion would freeze or cut market basket updates for post-acute care providers. Congress should reject this recommendation for IRH/Us, a sector that has been cut significantly in recent years even though no unconstrained growth or spending problems exist. Before considering any further post-acute care cuts, Congress should take into account the significant reductions that are already in place or about to be implemented for IRH/Us.

Congress recently enacted significant cuts for IRH/Us. The Budget Control Act of 2011 included a two percent sequestration cut to Medicare payments. This cut is particularly significant for rehabilitation hospitals/units because on average, 60 percent of patients in IRH/Us are Medicare beneficiaries. The Affordable Care Act (ACA) also subjects inpatient hospitals, long-term care hospitals, IRH/Us, psychiatric hospitals, and outpatient departments of hospitals to across the board cuts totaling $156.6 billion over ten years. Notably, the amount and impact of these cuts will grow over time, meaning that their total impact will not be fully understood in the short-term. It should be noted that the ACA cuts impacted hospital-level care provided by IRH/Us and LTACHs, *but do not apply to SNFs or HHAs*. These hospital and outpatient payment cuts will be incurred in addition to a $4 billion cut (over ten years) to IRH/Us enacted by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). MMSEA froze the IRH/U market basket update at 0 percent from April 1, 2008 through the end of Fiscal Year 2009—the rehabilitation hospital field endured six full quarters without any market basket updates. Rehabilitation hospitals and units simply cannot continue to absorb additional payment reductions without such reductions adversely affecting patient access.

These proposed cuts are unwarranted for IRH/Us. Unlike other post-acute care providers that have experienced explosive growth, rehabilitation hospitals and units have seen dramatic declines in utilization over the past eight years. Since 2003, IRH/Us have had the lowest Medicare spending growth of any post-

acute care provider and growth has been negative in three of the last five years. An analysis of eRehabData® shows that the total number of annual Medicare admissions has declined since the third quarter of 2003 by nearly 155,000 patients. A recent Moran Company analysis reported that Medicare IRH/U volume in the second quarter of 2012 is down 24.4 percent from the comparable period in the second quarter of 2004.[4] In addition, the number of providers has shrunk from 1,211 in 2003 to 1,162 in 2013, while the number of beds has fallen from 38,765 in 2005 to 38,265 in 2013. This has diminished capacity exactly when the large wave of American baby boomers will be placing increased demand for services on the field. Market basket reductions would further negatively impact patient access to rehabilitation care.

B. The 75% Rule is an Arbitrary Quota System that Wrongly Emphasizes Diagnostic Categories and Numeric Thresholds over the Needs of the Patient

Another proposal calls for an increase of the compliance threshold to 75 percent beginning in 2014. This policy would require 75 percent of an IRH/U's patients to have one of 13 specified diagnostic categories before it could qualify as an IRH/U for payment purposes. This policy is known as the "75% Rule" and is one of the Medicare IRH/U classification criteria.

The 75% Rule is a dated policy that has been soundly rejected by Congress in the past. In 2004, the CMS began phasing in regulations in 2004 implementing a new 75% Rule. Congress quickly recognized that the new 75% Rule was adversely affecting access to medically necessary rehabilitation services for vulnerable elderly and disabled patients and placing insurmountable stress on IRH/Us. In order to comply with the 75% Rule, IRH/Us oftentimes were forced to decline admitting patients based on their condition category—despite the fact that they needed IRH/U care for medical rehabilitation.

MMSEA permanently reduced the compliance threshold percentage for this classification criterion to 60 percent. In response to this permanent statutory relief, IRH/Us agreed to self-fund this regulatory fix through supporting a zero (0) percent market basket update from April 1, 2008 through the end of Fiscal Year 2009—six full quarters without a payment update. No other post-acute care providers or hospitals were subject to this or any comparable reimbursement cut. In addition, Congress directed CMS to conduct a study and analysis of the 75% Rule, which was performed by RTI and released by CMS in September 2009. The study did not recommend changing the current compliance threshold percentage of 60 percent.

There were many good reasons why Congress soundly rejected the 75% Rule. As expressed by the MedPAC Chair and Deputy CMS Administrator in recent House Ways and Means Committee hearings, the 75% Rule is a "crude" and "arbitrary" standard.[5] The 75% Rule is an arbitrary quota system that wrongly emphasizes diagnostic categories and numeric thresholds as a defining characteristic of IRH/Us. The policy is not a standard by which to judge the medical appropriateness of individual patients. Indeed, the arbitrary nature of the policy was evident in 2004 when CMS began enforcing the new 75% Rule. Because of IRH/Us' need to manage to the percentage threshold, there were many instances in which patients were accepted for admission one month, while patients with the same condition and clinical profile and in need of the same treatment were not able to be admitted the following month. The 75% Rule had the effect of overriding physician decisions and patient needs in order to achieve regulatory compliance.

[4] The Moran Company, Utilization Trends in Inpatient Rehabilitation: Update Through Q2 2012, October 2012.
[5] Testimony of Glenn Hackbarth, J.D., M.A., Chairman, Medicare Payment Advisory Commission (MedPAC) before the U.S. House Ways and Means Health Subcommittee, May 15, 2013.

The dated 75% Rule policy also fails to take into account current regulatory requirements facing IRH/Us. CMS adopted new, more restrictive medical necessity coverage criteria in January 2010.[6] Under these criteria, every patient admitted to an IRH/U is subject to an intensive pre-admission screening to determine the appropriateness of intensive rehabilitation therapy. This review must be completed by a licensed rehabilitation physician within 48 hours immediately preceding the IRH/U admission and must be documented in the patient's medical record. Following admission, the rehabilitation physician must conduct a post-admission review within 24 hours to ensure the patient remains appropriate for treatment in an IRH/U and to begin the development of the patient's course of treatment. A rehabilitation physician must then develop a plan of care within four days of the patient's admission to the IRH/U. The plan of care must detail the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRH/U stay, thereby supporting the medical necessity of the admission. In effect, these stringent criteria currently serve as a "100% Rule," with all IRH/U patients subject to extensive scrutiny before and after admission to the IRH/U. This policy has further constrained growth and admissions in a significant way.

Additionally, the ten-year-old 75% Rule recommendation does not adequately reflect the advances in medical care and technology that have created new populations who require inpatient hospital-level rehabilitation. These include, among others, patients with cancer, cardiac diseases, pulmonary diseases, organ transplants, and artificial heart pump implants. Even with these new populations, inpatient rehabilitation spending as a percentage of Medicare has been declining and now is essentially flat.

Some proponents of the policy change maintain that the government would realize savings from new implementation of this policy. However, in reality the federal government is unlikely to realize such savings. In response to the 75% Rule, IRH/Us irreversibly modified their admission practices to come into compliance and reduce costs. Patients were shifted to SNFs or home health agencies. The highest percentage of Medicare patients now being treated in IRH/Us includes extremely medically complex individuals with complicated diseases, conditions, and other neurological impairments that are more severe, more costly to manage, and require longer lengths of stay. These patients simply could not and would not receive the appropriate intensity of care in other post-acute care settings, such as nursing homes.

If the Committee decides to explore enactment of the 75% Rule more fully, AMRPA requests that the Committee work closely with us in designing the policy.

C. Shifting to "Site Neutral" Payments Fails to Recognize the Differences between Sites of Post-Acute Care

Another troubling proposal mentioned in the Committees' letter is to equalize payments for certain conditions treated in IRFs and SNFs. This proposal is usually referred to as "site neutral payment."

This proposal is deeply flawed. Site neutral payment policy fails to consider the clinical needs of patients in making decisions about the best course of care. In addition, it does not take into account the fundamental differences in staffing quality, outcomes, and levels of care among post-acute care providers. It also fails to recognize the stringent requirements placed upon IRH/Us that do not apply to other post-acute care providers such as nursing homes. Site neutral payments represent a redistributional proposal under which some providers will gain market share of patients and payments at the expense of clinically-appropriate, hospital-level, quality care.

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[6] *See* Medicare Benefit Policy Manual, Chapter 1 – Inpatient Hospital Services Covered under Part A, 110.

As mentioned earlier, Medicare requirements for IRH/Us are stringent and different from other post-acute care providers. To be classified as an IRH/U, the hospital must have a medical director and nurses who specialize in rehabilitation, have 60 percent of admissions from 13 specific diagnoses, and can only admit patients who need 3 hours of therapy a day and have the potential to meet predetermined goals. No other post-acute care provider is subject to similar requirements.

Site neutral proposals fail to recognize these fundamental differences in regulatory requirements, staffing levels, and resource utilization between and among sites of care. Congress cannot impose site neutral payment rates without concurrently also creating site neutral regulatory standards. In the absence of parallel regulatory, staffing, and cost-structures, Medicare must appropriately compensate IRH/Us. Because IRH/Us only admit patients who require hospital-level care and resources, Medicare must pay hospital-level rates for this level and intensity of care. A proposal to establish "site neutral" payments ignores the IRH/U physician, nursing, hospital infrastructure, and related costs that are not covered by SNF rates or required of SNFs.

Numerous studies have demonstrated that patients receiving rehabilitation in the IRH/U setting have superior functional outcomes compared to those treated by other post-acute providers, including stroke, hip replacement, and hip fracture patients. A report prepared for CMS by RTI found that, generally, stroke patients treated in IRH/Us have greater improvement and shorter stays than stroke patients treated in SNFs.[7] Other studies support these findings. A study by Kramer et al. reported that stroke patients who were treated in an IRH/U achieved greater functional improvement compared with patients treated at a SNF.[8] Many studies have also demonstrated superior patient outcomes when hip fracture patients were treated in an IRH/U.

IRH/Us also achieve superior results in a shorter amount of time compared to other sites of care. MedPAC found that IRH/U patients had an average length of stay of 13 days in 2011[9] compared to patients in a relatively efficient nursing home who averaged 34 days in 2009.[10] Studies by independent experts have found similar data. Munin et al. found that IRH/U patients stayed an average of 12.8 days while SNF patients stayed in the facility an average of 36.2 days.[11] SNFs are paid on a per diem basis, meaning that longer lengths of stay increase costs to the beneficiary and the Medicare program.

Moreover, an important measure of quality rehabilitation care is the percentage of patients that are discharged to the community, rather than another acute or post-acute care setting. According to CMS, a significantly higher percentage of IRH/U patients (81.1 percent) are able to be discharged to home after rehabilitation than nursing home patients to the community (27.8 percent).[12] Numerous academic studies have also demonstrated that patients who received rehabilitation in IRH/Us return to the community more often than those treated in SNFs.[13]

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[7] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, p. 212 (March 2011), http://www.medpac.gov/documents/Mar11_EntireReport.pdf.

[8] Kramer AM, Steiner JF, Schlenker RE, et al: Outcomes and costs after hip fracture and stroke. A comparison of rehabilitation settings. *JAMA* 1997;277:396-403.

[9] MedPAC March 2013 Report to Congress.

[10] *Id.* at 163. *See also* Centers for Medicare and Medicaid Services, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012, 76 Fed. Reg. 48486, Aug. 8, 2011.

[11] Munin MC, Seligman K, Dew MA, et al: Effect of rehabilitation site on functional recovery after hip fracture. *Arch Phys Med Rehabil* 2005;86:367-72.

[12] Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012 Final Rule, p. 48499 http://www.gpo.gov/fdsys/pkg/FR-2011-08-08/pdf/2011-19544.pdf (last visited October 25, 2011) and MedPAC March 2013 Report to Congress.

[13] Walsh MB, Herbold J: Outcome following rehabilitation for total joint replacement at IRF and SNF: A case-controlled comparison. *Am J Phys Med Rehabil* 2006; 85:1-5. Munin MC, Seligman K, Dew MA, et al: Effect of rehabilitation site on

Interestingly, CMS has failed to comprehensively analyze the comparative costs of medical rehabilitation as compared to SNF-level care over an entire episode of care. When one takes into account readmission costs (SNFs have readmission rates twice that of IRH/Us) and the higher percentages of discharge to home and community, the reality is that rehabilitative care may be the less costly alternative for many Medicare beneficiaries.

Because rehabilitation hospitals and units are able to deliver high quality care that enables most patients to return home more quickly, the Center for Medicare Advocacy and others recognize that any cost savings per treatment episode to be achieved by shifting patients from IRH/Us to other providers will be minimal at best. Rather than simply comparing per day costs of IRH/Us and nursing homes, total costs per episode of care should be compared. As noted above, significantly longer lengths of stay, higher readmissions, and lower rates of discharge to the community from SNFs add significant costs to the Medicare program that are not accounted for when simply comparing per day costs. In addition to considering costs, the comparative quality and scope of care, as well as patients' health status at discharge and beyond, must be considered in order to meaningfully assess whether nursing home care is actually less costly.

IV. Congress Should Support Forward-Thinking and Effective Reforms to the Post-Acute Care System, Including Implementation of the Continuing Care Hospital

AMRPA agrees that the post-acute care delivery system should be improved by moving from a provider or facility-centered to a patient-centered payment system and by improving care coordination. AMRPA has long been at the forefront of developing forward thinking solutions to challenging issues. For example, AMRPA developed the Continuing Care Hospital (CCH), a pilot project that will help move Medicare toward a more patient-centric delivery system model in post-acute care. The CCH represents a significant development in the ongoing effort to reform post-acute care and is consistent with the Committees' desire to ensure the right patients are receiving the right care at the right time. Despite a Congressional mandate in the ACA to implement the CCH, CMS has failed to do so to date. AMRPA calls on Congress to ensure that CMS implements this important pilot, and to expand it, if successful.

A. The CCH Would Reduce Costs and Improve Care by Moving to a Patient-Centric Delivery System Model

The CCH is an amalgam of the care settings currently described as LTCHs, IRH/Us, and hospital-based SNFs that are organized, in part, to deliver intensive rehabilitation therapy programs, as well as the medical component. 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 also determine which intensity of care the patient would need. Payment would be determined by the patient's clinical and functional characteristics. Creation and use of performance and outcome measures are a critical component of the model. This model centers admission, treatment, and payment decisions on the needs of the patient, rather than concentrating on the specific type of the provider of care.

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functional recovery after hip fracture. *Arch Phys Med Rehabil* 2005;86:367-72. Kramer AM, Steiner JF, Schlenker RE, et al: Outcomes and costs after hip fracture and stroke. A comparison of rehabilitation settings. *JAMA* 1997;277:396-403.

By focusing on the post-acute care hospital continuum, the CCH provides an innovative delivery system model and an alternative to some of the concepts proposed by MedPAC, the Obama Administration, and the Senate Finance Committee, including total acute and post-acute care bundling. The CCH model will improve quality by allowing for appropriate care based on patient need, removing barriers to access caused by the current provider requirements and payment systems, and promoting collaboration.

Additionally, the CCH model will decrease costs by creating efficiency, eliminating regulatory and administrative costs, avoiding confusing post-acute care requirements, and eliminating the costs of multiple admissions.

B. The Agency has Failed to Implement the CCH Pilot Despite a Congressional Mandate

Unfortunately, this pilot has not been implemented by CMS despite the statutory requirement. Under the ACA, the Secretary of HHS must implement the CCH Pilot. Section 3023 of the ACA requires the Secretary to conduct a National Pilot Program on Payment Bundling. The ACA goes on to state that the Secretary "*shall*" (emphasis added) apply the provisions of the bundling program "to separately pilot test the continuing care hospital model." [14] The use of the term "shall" takes discretion from the Secretary with respect to implementation of the CCH. The language is clear—Congress has required the Secretary to test the CCH model.

In establishing the CCH model, the statute states that "the provisions" of the bundling pilot shall apply to the CCH with a few defined exceptions.[15] One of the provisions applicable to the bundling pilot—and by extension to the CCH model—is the effective date. The bundling pilot is to be implemented "not later than January 1, 2013." The failure by the Secretary to establish the CCH pilot by this date was a clear violation of the statute. To date, the Agency has shown no progress towards implementing this pilot.

C. The Agency's Bundling Initiatives Do Not Satisfy the Spirit of the Law

Some officials in the Agency have reported that CMS has complied with the "spirit" of the law by implementing various bundling pilot projects. This contention falls on its face. Because Congress requires the Secretary to test the CCH concept, an assertion that the Secretary and Department pursued the spirit of the law falls short. Even if one accepts that implementing a statute should proceed through an amorphous understanding of the spirit of the law, CMS' contention that is has followed the spirit of the CCH section fails on both interpretive and practical grounds.

First, such an argument misinterprets the spirit of the law. It is clear from the drafting of the statute that Congress intended that the CCH be tested. The CCH model is listed in two separate portions of the statute. The first section, as described above, requires that the CCH be tested as part of the National Pilot Program on Payment Bundling. However, Congress also took further steps to ensure the CCH model would be implemented. Section 3021 of the ACA creates the Center for Medicare and Medicaid Innovation (CMMI) and lists specific, detailed models the Secretary may test. One of these models is the CCH.[16] By including a second statutory section discussing the CCH, Congress is establishing a backstop to ensure that the Secretary implements the model. That the Congress would go to such lengths to ensure implementation of the CCH demonstrates the project's importance to Congress. The Secretary must implement the CCH because it is required by statute and consistent with legislative intent.

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[14] Sec. 10308 of the ACA.
[15] *Id.*
[16] Sec. 3021 of the ACA.

Additionally, implementing bundling demonstration programs does not fulfill the statutory requirement to test the CCH because of the fundamental differences between the bundling pilots and the CCH concept. On August 23, 2011, CMS invited providers to apply to help test and develop four different models of bundling payments as part of the Bundled Payment for Care Initiative (BPCI). These four models are so different in practice from the CCH that they do not fulfill the statutory mandate to implement the CCH.

As noted above, the list of CMMI's potential projects includes the CCH. Thus, in theory, the CMMI could satisfy the statutory mandate to test the CCH concept if it were to engage in a CCH pilot; however, the Agency has not done so with the BPCI. The statute authorizes the CMMI to implement a model of "continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or nursing care during an inpatient stay and the 30 days immediately following discharge."[17] None of the four bundling models meet this definition of the CCH.

Model 1 of the bundling initiative is titled "Retrospective Acute Care Hospital Stay Only." The episode of care for this model would be defined as the inpatient stay in the general acute care hospital. Because the CCH focuses on a stay in a comprehensive CCH plus 30 days after discharge, this model is not similar to the CCH.

Model 2, "Retrospective Acute Care Hospital Stay plus Post-Acute Care," comes closer to fitting the CCH characteristics but still does not meet the statutory mandate to test the CCH concept. In Model 2, the episode of care would include the inpatient stay and post-acute care and would end, at the applicant's option, either a minimum of 30 or 90 days after discharge. This model differs from the CCH because there is no indication that the model integrates care like the CCH. One of the benefits of the CCH is its emphasis on eliminating silos of care and basing treatment decisions on what is best for the patient. There is no indication that Model 2 would achieve these ends.

Model 3, Retrospective Post-Acute Care Only, would begin at the initiation of post-acute care and would include the participation of a SNF, IRF, LTCH, or HHA. Again, because the care is not integrated, this model does not satisfy the requirement to test the CCH.

Finally, Model 4, Acute Care Hospital Stay Only, involves only the inpatient stay. Because the CCH focuses on post-acute care, Model 4 does not satisfy the requirement to test the CCH.

That the BPCI does not work as a substitute for the CCH is borne out by the experiences of a number of rehabilitation hospitals/units. A significant number of rehabilitation hospitals submitted letters of intent and attempted to participate in the BPCI but could not because of the structure and design of the project as well as problematic data issues. Indeed, it is questionable whether the Agency has found any entities meeting the definition of CCH that are able to participate in the Initiative. Inability to do so may, in fact, demonstrate a disconnect between the requirements of the Initiative and the characteristics of the CCH.

For all these reasons, implementation of the BPCI does not fulfill HHS' statutory requirement to implement the CCH model pilot in Section 3023. We request that the Committees use their oversight authority to ensure implementation of the CCH pilot by CMS.

[17] Sec. 3021 of ACA.

V. AMRPA Responses to Specific Questions and Options for Reforming Post-Acute Care

QUALITY

The Committees solicit feedback on several questions related to quality. AMRPA has done significant work in this area. In 2009, AMRPA created a Quality Committee, which has since worked to improve quality and develop quality measures for the rehabilitation industry. The purpose of the Committee is to: (1) explore the current status of definitions, development and use of quality measures and indicators; (2) define principles pertaining to quality care in IRH/Us; (3) adopt a framework for analyzing measures; and (4) define such measures. The Quality Committee also analyzed the strategic considerations for promoting such measures in various forums, as well as the role of other types of entities such as Patient Safety Organizations (PSOs) and data networks.

The mission of the Quality Committee is to identify structures and processes that lead to achievement of high quality outcomes and demonstrate achievement of those high quality outcomes. Our vision is to assure that outcomes are measured accurately and consistently without excessive burden for the provider or patient. Outcomes must be relevant, meaningful, and understandable for the patient and the provider. Selected outcomes would ideally show that care is delivered in the absence of preventable negative occurrences and promotes positive outcomes, with meaningful patient progress and in a cost effective, efficient manner.

Question 1: How can payment reforms be structured to incentivize improvements in quality of care, including improvement in care transitions?

AMRPA believes that the focus of payment reforms should not be limited to consideration of cost or achieving cost savings. Instead, ensuring that the payment system is patient-centered and assures access to care as noted above should be the principle factors in the selection of any alternative payment methodology. In addition, several principles should form the foundation of any quality improvement and payment reform efforts. They are:

- Promote safety/ prevent illness or injury;
- Promote goal achievement;
- Demonstrate value/ benefit;
- Promote integrated, seamless care;
- Promote/ assure social justice; and
- Promote access to complex medical rehabilitative care.

Additionally, we recommend that any quality improvement initiatives associated with payment reform consider quality measures or quality improvement activities that fit into one of the following categories and represent the:

- Absence of adverse events;
- Achievement of positive outcomes; or
- Demonstration of effectiveness/efficiency.

Finally, we suggest that any efforts to incentivize improvements in the quality of care reflect the following attributes:

- A low collection burden for providers and beneficiaries;
- Easily comprehensible for beneficiaries;
- A high level of significance to patients and providers;
- Data are routinely reported.

Finally, we believe that shared risk between acute and post-acute care providers would incentivize improvement in the quality of care for care transitions. For example, a shared risk/penalty for readmissions or pressure ulcers that originate in acute care but worsen in the post-acute care setting would help ensure both settings more actively engage in facilitating a patient's successful transition from one setting to another.

Question 2: What quality measures already exist or are already under development that can be used to advance PAC payment reforms?

In pursuit of AMRPA's commitment to quality, as noted above, we have been working over the last two years to develop quality measures. AMRPA conducted a broad environmental scan of all existing measures as well as using its own expertise. It examined measures from National Quality Forum (NQF), Agency for Healthcare Research and Quality (AHRQ) measures clearing houses, RAND Corporation, the 2005 RTI report, Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission, the National Database of Nursing Quality Indicators® (NDNQI®), and others. The Quality Committee has drawn upon existing measures such as the AM PAC, the CARE tool, the Barthel Index, and the IRF-PAI. The measures discussed below are specific to medical rehabilitation services. AMRPA does not favor only cross-setting measures at this time because quality care is not the same in various sites of service and sufficiently sensitive measures have not yet been developed. As such, AMRPA suggests adoption of rehabilitation-specific measures in most instances. Assuming the quality reporting data will be available to the public, it is critical that any quality measures be fully explained in terms understandable by the general public on the reporting website. Consumers should be able to easily understand the data that is presented to them. Providers should have an opportunity to review any data before it is reported to the public.

In addition to sharing our environmental scan for quality measures appropriate for rehabilitation services; we believe it is important to provide the Committee with some context of progress in quality metric development during the last three years. For example, Section 3004(b) of the ACA requires the Secretary to develop a quality reporting program for IRH/Us. To implement this mandate, CMS finalized two measures, catheter acquired urinary tract infections (CAUTI) and pressure ulcers that are new or worsened, in the FY 2013 IRF PPS. In addition to its FY 2014 IRF PPS rule, CMS has proposed additional measures for subsequent years on the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) including a revised measure for pressure ulcers, influenza vaccination coverage among healthcare personnel, percent of residents or patients who were assessed and appropriately given the seasonal influenza vaccine, and an all-cause unplanned readmission measure for 30 days post-discharge from the IRH/U.

In addition, CMS has engaged the NQF to assist it in reviewing quality measures it may propose for use in its various payment systems through a rulemaking process. NQF has established the Measure Applications Partnership (MAP) with several workgroups including the Post-Acute Care/Long-Term Care (PAC/LTC) Workgroup of which AMRPA is a member. These workgroups review measures under consideration for adoption by CMS and issue to the Agency an annual pre-rulemaking report which highlights, which measures are ready for inclusion in CMS' quality improvement initiatives, which measures are not ready or not appropriate for inclusion in these initiatives, and areas for which measures should be developed but for which no measures currently exist (referred to as measures gaps). We believe

that any measures under consideration should be vetted through the MAP workgroups as this process includes stakeholder experts across the spectrum of healthcare including consumers, providers, and payers, and provides sufficient opportunity for public comment.

1. Measures That Can Readily Be Adopted

AMRPA supports the use of the measures below. The majority have already been reviewed and endorsed by NQF or other entities.

a. Falls

The Quality Committee supports falls as a measure. However, there was concern that falls in the IRH/U setting have a therapeutic purpose in several instances and this fact needs to be recognized. The Quality Committee considered several NQF measures and NQF-endorsed measures.

Many IRH/Us currently track falls and their circumstances. As noted above, patients may be taught how to fall safely, how to recover from falls, as well as how to prevent them in IRH/Us.

We suggest CMS adopt the NQF-endorsed Nursing Sensitive Care Performance Measure I-NSC-5 or 4, all documented falls by a patient with an injury level of minor (2) or greater. The measure might be: did the patient have fall(s) during their admission? If yes, what was the outcome of the fall? (1) No injury; (2) minor injury; (3) moderate injury; (4) major injury; or (5) death. We believe this measure would be most effective because falls in rehabilitation hospitals and units can be planned or harmless, and this measure would reflect only those that cause injury. We believe that it would require risk adjustment (as a quality measure).

b. Pain

AMRPA suggests that CMS adopt NQF Measure 0420. NQF Measure 0420, Pain Assessment Prior to Initiation of Patient Therapy. Percentage of patients with documentation of a pain assessment (if pain is present, including location, intensity and description) through discussion with the patient, including the use of a standardized tool on each initial evaluation prior to initiation of therapy and documentation of a follow up plan. A pain assessment is a critical clinical process and helps determines treatment in the plan of care. Most IRH/Us use a pain assessment tool in their patient assessment process.

c. DVT/PE Prophylaxis

AMRPA suggests adoption of NQF measure 0376; however, this measure may need to be amended to clarify it intends to assess the number of patients diagnosed who were determined to be appropriate for prophylaxis and did not receive the prophylaxis between IRH/U admission and the diagnostic testing order date. This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present on arrival) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.

d. Discharge Status

AMRPA wishes to emphasize the need for a quality of life adjustment and the impact the community discharge indicator would have on the types of patients admitted and potentially other admission practices.

AMRPA believes the measure should be managed by the expectation for discharge as stated in the plan of care. Hence, the denominator would be managed by the expectation stated in the plan of care (POC). This may result in the plan of care indicating that discharge to home is not the goal. If the POC expectation is met, the discharge was successful, barring unforeseen events (see below).

AMRPA proposes the following exceptions to managing by expectation of discharge location:

- The measure needs to be risk adjusted by diagnosis (e.g., vent patient where plan was for home discharge but family determined it would not be able to care for the patient).
- The measure needs to include discharge to a lesser setting when it is not a function of the provider's care nor intention (e.g., family wants to take advantage of full Medicare SNF benefit of 100 days despite the rehabilitation physician saying the patient is ready to go home.)

AMRPA believes that discharge to community may not be an appropriate measure because at this time it needs further development. Community discharges currently include the following discharge sites on the IRFPAI: home, board and care, transitional living, intermediate care, and assisted living. These are the sites not included in the IRF PPS transfer policy. If CMS selects such a measure, it would have to be risk-adjusted. Such risk adjustment should include impairment categories, medical and functional status, demographic and other factors.

AMRPA cautions that if there is an emphasis on discharge to community without proper risk adjustment, this measure would readily create an incentive to decrease access. Providers may select only patients they are certain would be discharged to the community, and thereby not select those patients who are more complex with respect to functional and medical deficits, who do not have support at home for any necessary care, who have architectural barriers that may not be present as the functional deficits are resolved, or who present various other challenges to their recovery. This behavior is frequently referred to as selection bias or skimming. Additionally, patients who came from nursing homes and who were expected to return to nursing homes should not be included in the nominator or denominator of the measure.

AMRPA recommends including an adjustment for improving quality of life, particularly when it reduces the burden of care. It should be acknowledged that some patients may not be discharged to community but have seen their lives measurably enhanced. An example of this is improvement in a tetraplegic's ability to master their environment. One approach is to exclude those patients who would not necessarily be discharged home because of such issues.

This issue is also intertwined with difficulties in measuring functional change with current tools. The same tetraplegic patient may not ever show an improvement in functional scoring, yet may become independent in directing their care, thus enabling them to go home with support from a caregiver or to assisted living.

AMRPA believes that there should also be educational and explanatory materials to help consumers understand the numbers so that they would understand why the community discharge rate may not be 100 percent.

2. *Measures that Require Future Development*

a. Readmissions

We strongly encourage CMS to delay the implementation of a readmissions measure until it has been endorsed by the NQF MAP.

We believe that collecting data on readmissions from IRH/Us can be an indication of the quality of practice in both the IRH/U and the acute care setting, which refers the patients. It would be helpful to isolate many factors relating to these readmissions in order to resolve why they occur and seek to reduce them. The committee debated the use of readmissions as a quality reporting item. Most IRH/Us collect this information. For CY 2013, to date, readmissions to acute providers are at 12 percent according to MedPAC. Academic studies point to an even lower readmission rate for patients receiving treatment in IRH/Us for certain conditions.[18]

AMRPA sent extensive comments to CMS and RTI regarding the issues that must be addressed with respect to any readmission measure. CMS proposed a readmission measure in the FY 2014 IRF PPS proposed rule which reflects several recommendations. For example, at this time this measure has not been endorsed by NQF. Section 3004(b) of the ACA added Section 1886(j)(7) to the Social Security Act, which authorizes the Secretary to implement a quality reporting program for IRH/Us. The law generally requires the Secretary to specify measures that have been endorsed by an entity with a contract under Section 1890(a) of the Act. As CMS states in the rule, this contract is currently held by NQF. While the Secretary is given the authority to select measures in the case of a specified area or medical topic for which a feasible and practical measure has not been endorsed, AMRPA believes that the endorsement process through a consensus standard-setting organization such as NQF is critical to ensure this measure has been thoroughly vetted. In addition, any measure must account for unrelated readmissions which is not addressed, revising the formula used in acute care and adding risk adjustment factors, such as several aspects of socioeconomic status, which have a different effect in post-acute care than in acute care.

In the proposed rule, CMS states it will begin reporting feedback on performance for this measure to IRH/Us in CY 2016. Initial feedback will be based on CY 2013 and CY 2014 Medicare FFS claims data. However, CMS does not state how this feedback will be provided (*e.g.*, feedback report, on a website, in a letter to the IRH/U) or the process by which the IRH/U can appeal if it believes the data is inaccurate. We requested that CMS detail in the Final Rule the process by which this information will be shared with IRH/Us and how they can appeal any adverse findings.

[18] A recent study comparing IRH/Us and SNFs found that for patients discharged after hip replacement or repair, unplanned readmission within 180 days occurred at a rate of 12.3 percent for patients discharged to SNFs and only 4.2 percent for patients discharged to IRH/Us. These figures mean that a hip replacement patient discharged to a SNF is almost three times more likely to be readmitted within 180 days after acute care discharge than if he or she was discharged to an IRH/U. Because hip replacement patients are relatively stable, it is reasonable to think that for more medically complex patients, the difference in readmission rates between SNFs and IRFs is even greater. *See:* R. Riggs, P. Roberts, et al., Joint Replacement and Hip Fracture Readmission Rates: Impact of Discharge Destination, PM & R : The journal of injury, function, and rehabilitation, 1 September 2010 (volume 2 issue 9 Pages 806-810 DOI: 10.1016/j.pmrj.2010.05.008).

b. Functional Change

The Quality Committee extensively discussed the use of functional change as an appropriate measure. The Assistant Secretary for Planning and Evaluation (ASPE) has contracted with RTI to develop a measure of functional change and this work is ongoing. AMRPA cautions that none of the existing assessment items or tools are sufficient and continues to examine them. In addition, measuring function poses unique challenges. As ASPE and RTI proceed with their work, AMRPA believes that any functional change measure should acknowledge the following general characteristics or cautions:

- The measure should include motor functional change during the patient's stay. The Quality Committee rejected functional change by length of stay or by day as they provided perverse behavioral incentives.
- The measure should encompass self-care and mobility items.

There are no sufficiently sensitive communication and cognitive measures at present. Clearly, from the RAND research done in the development of the IRF PPS and the first set of refinements, the current IRF PAI measures are not sensitive enough to adequately assess the cognitive and communication status of patients and change in these domains. This issue arose in the discussions of the Technical Expert Panels (TEPs) on the development of the CARE tool and of the DOTPA instrument as well.

- Any measure will have floor and ceiling effects. This dynamic would for example, affect tetraplegics (floor effects) and joint replacement patients (ceiling effects). Hence, for patients who will truly benefit from the rehabilitation process, but will not register on a measure, there must be a way to account for the program and/or provider's quality in doing so. Hence, quality of life as measured by reduction in burden of care, increased mastery of one's environment, or other factors must be accounted for in any measure of functional change, any adjustments to such a measure, or use of such a measure.
- The measure must also be risk adjusted by diagnosis (RIC, IGC), demographic, and other factors.
- The measure should exclude patients discharged to acute hospitals or who died.
- There is a problem in that none of the existing items/ tools has been tested as quality measures.

AMRPA discussed the wisdom of adopting existing functional measures based on the guidelines adopted above, and started to examine measures including the AM PAC, CARE Tool, IRF PAI, and the Barthel Index. Each has its pros and cons and the Quality Committee has not endorsed any one of these measures to date.

c. Dysphagia Screening

Dysphagia screening is a necessary quality measure as a process measure. It would be most appropriately used with neurologically impaired patients. We do not have a recommendation at this time. We understand that the American Speech Language and Hearing Association is working on developing a measure.

Question 3: What gaps in PAC quality measures exist? What steps can be taken to accelerate development of measures to advance various PAC payment reforms and ensure continued improvement or evolution of measures in the future?

As a general rule, AMRPA believes that any measures under consideration should be vetted by the MAP for the reasons mentioned above including that it ensures broad stakeholder input and ample opportunity for public comment. As part of its work, the MAP has identified several gaps as detailed below. In its work, the AMRPA Quality Committee has also identified measure areas that would be appropriate for rehabilitation providers but have yet to be developed including:

a. Ability to Master Environment

AMRPA believes that a more detailed measure of the patient's ability to master his or her environment should be developed/ refined.

b. Patient Satisfaction Items

There are currently numerous patient satisfaction tools. They include the rehabilitation specific tool developed by eRehabData®, a tool from Press Ganey called the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), and others. A patient satisfaction tool should include patient experience survey questions measuring the patient-centeredness and overall satisfaction of the patient with their care. Patient satisfaction measures should be slated for future development and use because it will take work to standardize the questions and build a tool that measures the degree of patient-centeredness of care.

c. Communication/Cognitive

AMRPA believes that CMS should examine the Mini Mental exam for possible use as a long-term measure. It could also be used as a risk adjuster to explain certain population outcomes. For example, the presence of a depression item from the Mini-Mental State exam may show that a lower percentage of patients go home.

d. Mood

Depression and impulsiveness may be predictors of the cost of services as well.

In addition, AMRPA serves as a member of the PAC/LTC Workgroup of the MAP for the NQF. NQF has a contract with HHS to provide recommendations for measures under consideration for its various Medicare quality improvement initiatives. In its 2013 pre-rulemaking report issued to CMS, the MAP identified care coordination, functional status, and medication reconciliation as well as safety issues that have high incidence in IRFs, such as MRSA, falls, CAUTI, and clostridium difficile infections as gaps for which quality improvement metrics should be developed.

Finally, in order to accelerate the development of measures to advance post-acute care payment reforms, the Committees could consider testing measures in these settings by adding a minimal number of trial measures to the various data collection tools to collect data and then analyze this data to evaluate its usefulness in these settings. A critical element of this approach would be to ensure that the relevant provider groups are allowed to collaborate by providing input and helping with adjusting the measure before it becomes a quality reporting program measure.

Question 4: Are there current quality measures that can be applied across multiple PAC settings (i.e., functional status, mobility improvement, etc.)?

The Senate Finance Committee's work to identify measures that could be applied across multiple settings could be greatly informed by the work of the PAC/LTC Workgroup as convened by NQF. This workgroup is charged with providing input on matters related to the selection and coordination of measures for PAC/LTC providers, including hospices, IRH/Us, LTCHs, SNFs, and HHAs. As noted, the workgroup is comprised of a diverse group of post-acute care experts. It is evaluating carefully if and what measures can be applied across settings and meet the principles and goals established by the MAP in support of the HHS National Quality Strategy.

However, as noted above, AMRPA does not favor initially adopting cross-setting measures because what constitutes high quality care is different in various sites of service and requires different measures. For example, the NQF MAP and CMS considered the adoption of central-line acquired blood stream infections (CLABSI) but recognized that so few central lines are used in IRH/Us that in the rare instances in which one was used could inappropriately and significantly draw down an IRH/U's quality score. As such, AMRPA suggests adoption of rehabilitation measures and extensive consultation with experts prior to the application of a measure to all current PAC/LTC sites of care.

ASSESSMENT TOOLS

Question 1: To what extent can existing patient assessment instruments, including the Outcome and Assessment Information Set (OASIS), Minimum Data Set (MDS), or IRF Patient Assessment Instrument (IRF PAI), be used or modified to help form the foundation for broader payment reform, like bundling and site neutral payments?

A critical challenge relating to the use of the various setting-specific assessment tools currently used by the Medicare program is that they do not collect the same data. The data that each tool collects are collected in a different manner, with different data elements. For example, many of these assessment tools collect data on function, mobility, and self-care but use different scales and collect this information at different points of time during the episode of care. While some of the data elements carry similar titles and are collected on these various assessment tools, changes would be required to align these tools. An extensive examination of each tool and all items collected is necessary before utilizing them in any common tool. The project leading to the Continuity and Record Evaluation (CARE) is the first effort along these lines.

Question 2: To what extent is the CARE assessment tool useful in helping determine appropriate care settings for patients?

At this time, there are multiple versions of the CARE tool with variations based on the setting of care. While there has been great interest in the use of the CARE tool to determine the site of care, it is not necessarily intended for this purpose. In its current form, it is an assessment tool not a placement tool and modifications would be needed to transition the tool for use in patient placement.

Question 3: What aspects of the CARE tool need to be improved to ensure accuracy in reporting to CMS, public reporting, or for use in payments? The Center for Medicare and Medicaid Innovation (CMMI) has proposed using a modified version of the CARE tool as part of the Bundled Payments for Care Improvement (BCPI Initiative). Is the B-CARE tool (modified CARE tool), currently proposed for use by the BCPI program a more appropriate measure?

Several AMRPA members participated in the development and testing of the CARE Tool. We recognize that it is possible it could be used in the future for payment and quality improvement purposes. As a result, our members have undertaken an extensive review of the tool and have included in Appendix A our suggested revisions. When the tool was originally developed, it was considered a uniform reporting tool, not necessarily a tool for payment. Various iterations are being proposed for various sites and purposes. All of them should be reexamined by testing with the intended payment model in mind before being proposed for adoption.

In addition, AMRPA has identified three key issues that will need to be addressed prior to the implementation of the CARE Tool including:

1. At this time, each section of the CARE Tool yields a score relevant to the items within that section. However, it is unclear how the score for each section will be used to calculate a total score for the patient or if that is even the intent. Understanding how the score for each section will be used to develop a more complete picture of the patient will be critical.

2. At this time, the CARE Tool is strictly an assessment tool and is not used for reimbursement purposes. Work will need to be done to determine how the results of the CARE Tool for a particular patient will be used to determine the reimbursement.

3. Finally, it is important to determine how the CARE Tool will be used in the existing regulatory framework, particularly for IRH/Us. After the CARE Tool demonstration was initiated, several regulatory changes were imposed on IRH/Us by CMS. In 2010, new requirements such as a pre-admission screening were applied to IRH/Us and coverage and documentation requirements such as this are not required for any other post-acute care provider. While the pre-admission screening is helpful in determining the appropriateness of an inpatient rehabilitation admission, it does impose an administrative burden on IRH/U staff. CMS should consider the combined administrative burden of the CARE Tool and the coverage criteria revisions from 2010 to limit this burden whenever possible. In addition, the CARE Tool does not capture many of the elements of the pre-admission screening, which contain important, clinically relevant information about the patient. It should be determined whether this information could be collected via the CARE Tool or if adjustments to the CARE Tool, the pre-admission screening, or both should be made to limit the administrative burden while maintaining documentation regarding the patient's condition to assist in the patient's treatment.

Question 4: What other tools can be used to enhance a referring provider's ability to ensure beneficiaries receive care in the right setting?

Assessment and other tools are helpful adjuncts in determining the appropriate setting of care and range of services delivered to a patient, but no tool can completely replace the critical thinking skills and clinical judgment of a trained physician or clinician. For example, Medicare coverage criteria for IRH/Us require a pre-admission screening and post-admission evaluation to ensure a patient is an appropriate candidate for the range of intensive rehabilitation and other services a patient will receive in this setting. This

analysis is done by a rehabilitation physician, not a tool or checklist. To assume a tool alone will allow for appropriate decisions regarding the patient's best course of treatment does not account for the value of the one-on-one interaction that takes place between a patient and his or her clinical care team. Instead of a tool, closer care coordination should be encouraged. In this instance, the IRH/U and acute care physicians would join in rounds, assessing each other's treatment patterns for specific conditions and how they help or hinder appropriate referrals and outcomes.

Question 5: What is preferable: 1) adding new questions to existing assessment tools (OASIS, MDS, or IRF PAI); or, 2) capturing data elements in a new assessment tool?

To date CMS has added specific sections or questions from the CARE tool to the existing Medicare assessment tools as part of the quality reporting programs referenced above and in part due to its recognition that the CARE tool needs additional refinement. This approach has been the least disruptive to the provider community. While a new assessment tool, such as the CARE tool, may ultimately be the appropriate assessment tool for one or more settings, transitioning to a new tool will prove costly for healthcare providers and includes the training of staff and changes to electronic health record and billing software systems. As a result, the Committees may want to consider an approach that transitions over a period of time from the use of existing assessment tools to any new tools, such as the CARE tool, to minimize any negative financial or administrative burden.

VALUE-BASED PURCHASING

Question 1: Should the existing PAC system be transitioned to Value-Based Purchasing (VBP) and if so, what further steps are needed in order to make that transition? Should Congress consider a broader VBP program for all PAC settings, or pick specific settings? How soon should PAC VBP program(s) begin?

At this time, CMS is implementing a VBP initiative in several of its payment systems including the IPPS for acute care hospitals. Section 10326(b) of the ACA requires the Secretary to conduct a pilot for VBP in several post-acute care settings, including IRH/Us, by 2016. As the concept of VBP is further refined it may be appropriate to apply it to all post-acute care settings. However, when pay for reporting moves to pay for performance there is an even greater need to protect vulnerable patients against any perverse incentives leading to a decline in access or stinting on care.

Quality reporting for IRH/Us for Medicare purposes is relatively new. It was first required in Fiscal Year (FY) 2013 and additional quality measures are proposed in the FY 2014 IRF PPS for reporting in FYs 2015 and beyond. Before such measures can be used for VBP, we believe they should be subject to a minimum of two years of data collection as part of pay for reporting to allow for a period of feedback and adjustment. Also, any performance metrics used should not require 100 percent performance of the outcome or compliance with the process if a process-based measure is used. Instead, a realistic goal should be sought. Measures selected for either pay for reporting or VBP should be statistically valid and relevant to the setting to which they are being applied. Given these considerations, we do not believe VBP could be implemented in IRH/Us until at least FY 2016.

Question 2: What performance measures should be used to assess PAC performance improvement?

The metrics upon which any VBP may be based must be carefully crafted to avoid stinting on care or a decline in access. One clear example is discharge to the home. The definition of "home" becomes

critical. The current proposal to narrow that definition in the FY 2014 IRF PPS proposed rule could have long term implications for patients and any VBP program. A better measure in addressing discharge planning is whether the patient has met their goals. Function is also a highly nuanced measure that, if structured appropriately, may be used in IRH/Us. The Committee should be aware that there are multiple floor and ceiling effects with any measures.

On occasion, a primary reason for rehabilitation hospital care is to create a care setting and home environment that can be adapted to support the needs of a very severely disabled person, in order to avoid long term institutionalization. Hence, some patients will never look like their functional status has improved and the provider will be penalized. This situation could be true of tetraplegics, patients with severe brain injuries, and other neurological patients. The unintended result could be that providers may not admit harder cases involving more medically complex patients. A better approach is to have a corridor/other measure for those patients to encourage their treatment. For example, it would be appropriate to include a measure that demonstrates the patient's mastery of his/her environment via multiple means (*e.g.*, speaking, use of assistive technologies such as computers, etc.) as one alternative measure.

As mentioned in response to the first question on VBP, quality reporting is relatively new for IRH/Us for the Medicare program, as such it is too early to tell what measures might be appropriate for a VBP program. But many of the measures we mention above such as falls, pain management, and deep vein thrombosis could prove appropriate for such a program upon further development and refinement.

Question 3: What payment model should Congress consider for implementing a program and why? Should the system rely on penalties, rewards, a combination thereof, or something else? Should PAC VBP programs address both improvement and attainment on quality measures?

Any VBP program should include bonuses for performance that exceeds a benchmark or threshold as well as penalties as are now included in the IPPS VBP. As numerous stakeholders engaged in the area of healthcare quality improvement have noted, in some cases continued improvement is difficult if not impossible to achieve.

REDUCING HOSPITAL READMISSIONS

Readmissions are a function of the incentives inherent in the IPPS and the multiple other PPSs. For example, SNFs have an incentive to readmit patients because the SNF would not incur costly care of patients who become ill. Readmission rates vary widely among post-acute care settings. Government data and academic research show that the readmission rates for SNFs are substantially higher than for IRH/Us.

According to MedPAC the mean rate of SNF readmissions is 19 percent.[19] For IRH/Us, MedPAC cites a 12 percent readmission rate.[20] These numbers are not directly comparable since the IRH/U readmission rate refers to all readmissions after the end of the URH/U stay while the SNF rate reflect only persons discharged to acute care and includes only a subset of patients with avoidable conditions in the calculation. Taking these factors into account, the existing spread between IRH/U and SNF readmissions is likely far greater.

Academic research also shows a significant difference in readmission rates between IRH/Us and SNFs. A recent study comparing IRH/Us and SNFs found that for patients discharged after hip replacement or

[19] MedPAC, March 2013 Report to Congress (Table 8-5).
[20] *Id.* at 227.

repair, unplanned readmission within 180 days occurred at a rate of 12.3 percent for patients discharged to SNFs and only 4.2 percent for patients discharged to IRH/Us.[21] These figures mean that a hip replacement patient discharged to a SNF is almost three times more likely to be readmitted within 180 days after acute care discharge than if he or she was discharged to an IRH/U. Because hip replacement patients are relatively stable, it is reasonable to think that for more medically complex patients, the difference in readmission rates between SNFs and IRFs is even greater.

Various studies have shown that readmissions can be reduced by expanding the presence of physicians and registered nurses, improved discharge planning, compliance with treatment plans, medication reconciliation between sites, enhanced communication among the care team, and enhanced communication with the family and caregivers before and at time of discharge.

AMRPA has worked extensively to determine an appropriate readmission measure. For example, AMRPA's Quality Committee reviewed readmission measures, and AMRPA convened a committee to examine bundling and the concept of the CCH. Both committees discussed extensively the use of a readmission measure. AMRPA members participated in the Technical Expert Panels held by RTI and CMS to develop a readmission measure for IRH/Us. In addition, AMRPA commented to RTI and CMS about the measure during its development, as well as filing comment letters on the readmission measure proposed in the FY 2014 IRH/U Proposed rule. AMRPA has also commented on CMS' request for comments on a similar SNF readmission measure.

General Comments

Any readmission measures designed for post-acute care providers, particularly IRH/Us, should adhere to the principles for reform articulated above. Above all, any readmission program must be designed to be fair to providers and assure that access to the site of care is maintained and not jeopardized due to any incentive structure in the program.

There is a large and growing body of literature looking at the issue of readmission to acute care hospitals from various sites, including the home. The Post-Acute Care Payment Reform Demonstration (PAC-PRD) includes references to most of the current articles of interest. In addition, the AHRQ Healthcare Cost and Utilization Project (HCUP) has published two briefs – one on 30 Day Readmissions following Hospitalizations for All Cause Readmission by Payer and Age and one on Chronic vs. Acute Conditions for 2008. We also understand that CMS and RTI have been looking at a CMS-commissioned study from the Yale-New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (Yale) titled "*Hospital-Wide All Cause Unplanned Readmission Measure*." This report was reviewed by our committee. In addition, the National Quality Forum created a consensus standards endorsement project which recently issued a report titled "*Patient Outcomes: All Cause Readmissions Expedited Reviews 2011: A Consensus Report*" that discussed three potential readmissions measures and sought public comment thereon. AMRPA submitted comments.

As we develop policies to measure and prevent readmissions, we believe there are several factors to be considered in developing a measure that would be applicable to IRH/Us and other post-acute care sites.

[21] R. Riggs, P. Roberts, et al., Joint Replacement and Hip Fracture Readmission Rates: Impact of Discharge Destination, PM & R : The journal of injury, function, and rehabilitation, 1 September 2010 (volume 2 issue 9 Pages 806-810 DOI: 10.1016/j.pmrj.2010.05.008).

1. Data to be used for any analysis

As referenced below, CMS is relying heavily on the referenced Yale study in its design of readmission measures. It appears that the Yale study used data from 2007 - 2008 and apparently validated performance against data from 2009. Yale then grouped the 17,000 ICD-9-CM codes into condition categories and procedure codes using the AHRQ Clinical Classification Software. In the IRH/U setting, there is a much smaller number of cases overall, totaling approximately 359,000 Medicare fee-for-service cases in 2010 according to MedPAC's March 2012 Report to Congress. The number of readmissions (however defined) therefore is a considerably smaller number. Hence, we recommend that data from multiple years be used for any analyses, in order to provide a sufficiently robust data base.

Analyzing only one year of data may risk inclusion of an atypical year. For example, in the IRH/U space, there have been numerous regulatory changes. Starting in July 2004, the 75% Rule was rewritten which increased the compliance threshold annually from July 2004 to December 2007. This change, authorized by the Medicare, Medicaid, and SCHIP Extension Act of 2007, was followed by a statutory change mandating the threshold at 60%. In addition, CMS issued another comprehensive regulatory change to the Medicare IRH/U coverage criteria effective January 1, 2010, and to the classification criteria in the FY 2012 IRF PPS final rule. Also, the demonstration Recovery Audit Contractors in California and Florida in 2005-2007 were exceptionally active in denying IRH/U cases and the Fiscal Intermediaries, (now Medicare Administrative Contractors), conducted extensive medical necessity reviews and denials from 2004-2008. Each of these developments resulted in changes to the numbers and types of patients being admitted. Hence each year, starting in 2004, would show a change in case mix at a minimum. There was some stability from January 2007 to January 2010; however there are corridors in those years where providers continued to make changes given that there is a learning curve in adapting to the many new regulations. For example, we did not observe a large change in fee-for-service discharges starting in the first quarter of 2008 as one would have expected given that the compliance threshold was lowered from 65 percent to 60 percent. In fact, even to this day, the discharges have not increased to the earlier 2004 or 2005 levels. In addition, providers may have had to adjust their admission policies starting in late 2009 to conform to the new coverage criteria, which were effective in January 2010. Finally, by the end of 2010 the number of discharges started to stabilize, as seen in a very small increase in Medicare patients. In 2011, there was further change as the classification criteria were reorganized and modified. With so much change during and between years, Congress and CMS should rely upon multiple years of data as they design readmissions measures.

Second, we recommend that in addition to claims data, patient-specific data also be utilized. The IRH/U field is fortunate that it has had, and continues to have, a rich history of collecting patient-specific data and in using it internally for multiple purposes, including outcome management. IRH/Us have been required to complete the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) for purposes of the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) and the 60 percent threshold compliance calculations for ten years. This tool collects highly detailed information about a patient's diagnosis, co-morbidities and complexities, length of stay, motor and cognitive functioning, as well as discharge destination and initial referring site. It provides additional patient data that would be helpful in characterizing and understanding IRH/U readmissions patterns, patient characteristics, and risk adjustment analyses.

Third, we suggest that IRH/Us, LTCHs, and SNFs should each have their own readmission measure. Data should be split by type of provider and that additional provider-specific data may want to be considered, such as presence of a teaching program, being a rural provider, and other factors. We believe including these additional items in the data bank would help assure that any analyses conducted would

better capture the universe of IRH/Us and other post-acute care providers and their activity with respect to readmissions.

2. Inclusion and Exclusion

The type and nature of the cases included in the definition of the measure and its calculation is equally critical particularly when the measure is tied to payment incentives instead of only quality reporting. The Yale study sets forth patients to be included (*e.g.*, patients 65 or older, who survive hospitalization and are discharged home or to a post-acute care setting) and who are to be excluded for which it lists 7 categories.

For purposes of an IRH/U measure, we recommend that the measure include patients 65 or older, who, having survived the acute hospitalization, then survive the IRH/U hospitalization, who are discharged home, to another non-acute setting or to an acute setting.

One other issue is patients who die during the defined window of observation. Unfortunately, it is difficult to measure mortality in the sense of when and where someone died. If the patient is in a rehabilitation unit or hospital-based SNF they can be readily transferred to the acute care side of the hospital and be deemed to have been readmitted and died there. However, if a patient is in a freestanding rehabilitation hospital that is 20 miles away, they may not be transferred so readily and may die while at the freestanding IRF. Given these variances in geography and practice, we recommend that patients who died not be included in the measure. We also recommend that planned readmissions not be included in the measure (numerator or denominator).

3. Number of Measures

We support the use of one measure for a readmission reduction program for IRH/Us. The first such measure would be readmission within 30 days of discharge from the post-acute care setting to maintain symmetry with the other measures (IPPS and SNF) being discussed. At a later date, additional measures may be considered.

4. Definition of Readmissions

The definition of the readmission for any setting must consider several fundamental questions: was it planned or unplanned; was it preventable or unpreventable; was it clinically-related to the admission in question or not. These critical issues are discussed below.

5. Observation Window

The observation window is usually the period of time that will be included in the definition of a readmission. The most commonly discussed, and currently implemented, window is 30 days of discharge from the acute care hospital. We recommend utilizing this window for the initial readmission program.

6. Stratification of Cases

We do not believe all readmissions should be viewed as one large homogenous group. Instead, we recommend stratifying readmissions patients based on several factors. This would provide a finer description of the types of readmissions cases and their circumstances and may facilitate the identification of any patterns or trends. In addition, different groups have different risk factors associated with their readmissions.

The Yale study created five different models/strata: medicine, surgery/gynecology, cardio respiratory, cardiovascular, and neurology. Rehabilitation cases do not fall neatly into these five models and CMS did not adopt this part of the model when it proposed the readmission measure for IRH/Us. Instead, the rehabilitation field has a series of categories it has used for grouping conditions for over 20 years. They are the 21 Rehabilitation Impairment Categories (RIC). The categories reflect cases which are homogeneous with respect to clinical characteristics. AMRPA recommends that CMS and RTI look at various possible strata based on the RICs or other groupings for IRH/U readmissions measure(s).

7. Risk Adjustment

AMRPA strongly believes that proper risk adjustment is mandatory with respect to these measures. We expressed ourselves extensively on this point to CMS in two letters. Such adjustment is necessary to assure that any quality measure reflects the true picture of the provider reporting data on the measures. In addition, it is particularly critical to rehabilitation patients given their variability and complexity. For example, no two strokes are the same. Multiple factors can be included for risk adjusting, including demographics such as age, gender, and living status; medical status including co-morbidity, medical condition or diagnosis; functional ability including self-care, mobility, and cognitive; other severity factors; and case mix adjustment.

The Yale study uses a set number of factors based on the CMS Complications or Co-morbidities (CMS-CCs), which resulted in a final set of 31 risk variables. It did not include complications of hospitalization nor socioeconomic status, gender, race, or ethnicity. It did include service mix adjustment.

AMRPA believes that risk adjusting rehabilitation outcomes is more challenging than risk adjusting other clinical results. At the outset, characterizing rehabilitation interventions is frequently difficult. Furthermore, outcomes are diverse and depend on a myriad of factors, including patients' physical and cognitive abilities, underlying medical diseases, sensory and emotional factors, willingness to participate in care, and supportive environments.

With these cautions in mind, AMRPA has supported the Yale factors. However, we also recommend that age, overall functional ability, and family and support status be considered. Family and support status play a direct role in rehabilitation (as opposed to acute care) in determining discharge status and also plays a role in whether a patient is readmitted to the acute hospital or not after IRH/U discharge. For example, studies show that a male patient is more likely to be discharged home if he is part of an intact couple. The presence of an involved family, caregiver, or other supports or support system plays a large role in discharge site decisions, almost from the point of the admission. They can also affect a readmission in that if they are present they may help the patient make the necessary follow-up appointments, help the patient physically get to the appointment, make the next follow-up appointment, follow-up with therapy at home, help manage medications, assure community transportation is available (*e.g.*, bus or cab), and other service activities.

Question 1: Should Congress consider a broader readmissions reduction program for PAC settings or pick specific settings?

We believe that Congress should focus on setting specific readmission measures. Each site serves a unique patient population with a different mix of conditions and characteristics. These differences heavily influence patient and provider behavior. Using a generic readmission measure across sites would not adequately promote coordination of care and prevention of readmissions. Instead, we suggest continuing

to follow CMS' approach of having different measures for each setting. To date, CMS has developed measures for acute care, IRH/Us and recently issued a proposal regarding SNFs. The measures are for hospital-wide unplanned readmissions (without regard to the three conditions used in the IPPS hospital reduction program) and stem from the same study conducted by Yale mentioned above. However, in each instance there have been meetings with stakeholders which have resulted in changes to the measure reflecting the patients and circumstances of each setting. However, we believe that both the IRH/U and SNF measures require further refinement pertaining to the site and patient sensitivity.

Question 2: What payment model (penalty, saved savings, etc.) should Congress consider for implementing a readmissions reduction program? Can the SNF VBP demonstration or the hospital readmission program be used as a model for PAC readmission programs?

To the extent there are financial incentives involved with a readmission reduction program, we suggest using a shared savings model. Such an approach provides an incentive for both parties to improve their readmissions rates. The acute care readmission measure has several deficiencies. According to the MedPAC June 2013 Report to Congress, roughly half of the hospitals will be penalized for each condition covered by the policy. We understand that as national rates of readmissions drop the penalties for some hospitals may actually increase.

Furthermore, the penalty is disproportionate to the actual cost of excess readmissions. Therefore, we urge Congress to abandon the current IPPS approach for any further readmissions reduction programs. Instead, we recommend that a more positive incentive structure be established. One concept is shared savings which is currently in operation in various venues for various purposes (*e.g.,* ACOs). Savings calculations should recognize both payment penalties and reduced hospitalizations.

Question 3: Readmission reduction efforts can use measures of all cause readmissions (as is currently the case with the existing inpatient hospital readmissions program) or all cause measures that may be modified for exceptions such as non-preventable admissions (*e.g.* accidents). How well developed are those measures? Which type of measure is preferable and why?

AMRPA has examined various approaches to readmissions from condition-specific only to hospital-wide readmissions. First, as noted above, the current measures being considered for IRH/U settings and others need further development and thought. For example, they have not been reviewed or endorsed by NQF. Second, CMS' approach has been to adapt the one approach embodied in the hospital-wide readmission measure published in last year's IPPS final rule as a data reporting measure. When creating readmissions measures for post-acute care, we believe the base hospital-wide readmission measure requires amendment, and the penalty program and formula devised for the IPPS should not be carried forward to other providers as mentioned above.

It is also critical that the timeframe for measuring the readmissions is clarified since there is the potential for an overlap between the IPPS and post-acute care readmission timeframes. The IPPS timeframe is 30 days from acute discharge, while the timeline for post-acute care may be 30 days from the post-acute care discharge, as is the case for the proposed IRH/U measure. Since there can be a clear overlap, there is a need to clarify who will be held responsible for the readmission.

The current approach also excludes planned readmission events. CMS has taken the original list of planned events from the Yale study and then revised it for both the IRH/U and proposed SNF measures. However, we believe additional steps are required. There needs to be a further approach to identifying

and accounting for other factors involved in readmissions. The first is whether or not the readmission is clinically related to the original post-acute care admission (if looking at a post-acute care readmission) or unrelated to the original admission. Policy makers must be made aware that the clinical reason that a patient is admitted to an inpatient rehabilitation hospital or unit is frequently different from the reason for the admission to the acute care hospital. Hence, using the acute admission or discharge diagnosis as the basis for defining related -- unrelated readmissions from the post-acute care setting will frequently be clinically incorrect.

Furthermore, the current approach does not thoroughly examine whether the readmission is preventable. Planned readmissions are different from preventable readmissions. For example, an unpreventable admission may include a readmission for injuries due to some type of accident, such as an automobile accident or be one that exceeds the 30 day post-discharge window.

Finally, any readmission measure must be risk adjusted. The IPPS measure takes some steps toward case-mix adjustment, as do the proposed IRH/U and SNF measures. However, the risk adjustment factors are not sufficiently sensitive to the unique aspects of the patients in each setting. We would recommend that presence of family and care givers and other supports needs to be considered in risk adjustment. Frequently, decisions regarding discharge to home or community from the post-acute care setting pivot on these points and sometimes result in readmission to the hospital.

Question 4: Readmission reduction efforts can also use condition-specific measures or all condition measures. How well developed are those measures? Which type of measures, condition-specific or all conditions, are preferable and why?

AMRPA supports the all-condition measures approach to a readmission program. An all-condition admission approach – properly constructed regarding exclusions, risk adjustment, definitions of planned vs. unplanned, preventable or not and related or unrelated – requires the entire provider site to reassess its current practices that are resulting in readmissions. It also would provide incentives for the site to seek further coordination and communication with all of its referral sources. Also, a condition-specific only approach leads hospitals to favor quality improvement for treating only the identified conditions, possible to the detriment of other patients and programs. Such an approach may also skew patient selection away from these patients in favor of those not under the program, which would be a negative incentive to comprehensive patient care. However, and for reasons stated above, an all-condition or hospital-wide program needs further development focused on each of the separate post-acute care settings.

Question 5: Readmissions programs may need to rely on measures that are available and evolve to other measures that may be preferable for policy purposes; how can we assist in this evolution of measures?

It appears that the current approach is to work from existing hospital-wide readmission (HWR) and amend those slightly for specific post-acute care sites. The government should meet with stakeholders in seeking measures for use and in seeking to adapt any existing measures for use in alternative sites. Otherwise, poorly defined measures can result in perverse incentives leading to failure to admit patients initially; failure to readmit patients when clinically appropriate; death or other negative events. If one of the objectives of a readmission measure is to encourage coordination of care, better transitions, enhanced staffing competencies, and increased communication, then such measures should be structured to encourage these dynamics.

Additionally, further information and coordination between sites of care is critical. A fundamental challenge with being held accountable for post-discharge readmission rates is that the hospital may not know that the patient was readmitted, at least not in a timely manner. If a provider does not know of a readmission, it will be difficult for the provider to assess how its behavior may have influenced the outcome. Accordingly, the basic need is for a system that gives accurate and timely data to providers when subsequent health care services, including readmissions, have been utilized. This would include information on emergency room visits, actual admissions, observation days, and other health care interventions.

Question 6: How soon should readmissions reduction programs begin?

Readmissions reduction programs should not begin until measures are adequately developed and endorsed by NQF. In addition, providers should report data on readmissions for at least two years to become familiar with the measures, provide a database from which to develop a risk reduction program, and promote cooperation and coordination within their communities and among all referral sources. During those two years, there should be extensive provider education on the use of the measures and ways to mitigate readmissions. The data may subsequently be publicly reported if there are adequate educational materials explaining what the data means, as well as a public literacy campaign. Finally, in year 3, the financial incentives of payment reduction/or shared savings may be instituted to further incentivize providers to reduce their readmissions. At no time should the measure of success in reductions be zero. It is an unrealistic measure replete with disincentives. A more realistic goal should be established that rewards some level of improvement from facilities' historic experiences. For example, as providers gain experience and improve their readmission rates, the rates are likely to become more similar, and thus form fewer statistically different categories. In this situation, the rates of providers will tend to aggregate towards zero if they follow the pattern of other metrics CMS requires hospitals monitor and report. Thus, the statistically significant category that includes the highest performing facilities is likely to have a large number of providers that would be eligible for awards. The lower categories are likely to have very few providers that might be eligible for penalties.

Question 7: What other payment reforms can be made to incentivize post-acute providers to work with other care settings to lower the rate of readmissions?

As discussed previously, the CCH model provides a structure in which post-acute care providers would work together based on the needs of the patient. The CCH is an amalgam of the care settings currently described as LTCHs, IRH/Us, and hospital-based SNFs that are organized, in part, to deliver intensive rehabilitation therapy programs, as well as the medical component. 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). In either form, the CCH would be designed to eliminate silos of care and ensure that patients receive the appropriate level and intensity of care. The CCH model will improve quality and reduce readmissions by allowing for appropriate care based on patient need, removing barriers to access caused by the current provider requirements and payment systems, and promoting collaboration.

Another critical strategy in health care that has been associated with lowering readmissions is increasing coordination and easing care transitions. Information is now transmitted (or intended to be) via electronic health records. Unfortunately, many if not all, post-acute care sites are not included in the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, to receive Medicare meaningful use incentive funding. Hence, IRH/Us do not have incentives to develop or use EHRs or develop those that are compatible with

acute care providers. A second factor easing transitions would be to have a mutually agreed upon set of information that is handed off in the transition records when the patient is discharged from acute care. For example, currently, there is no information on swallowing status in the acute care information sent to the post-acute providers. However, all IRH/Us conduct such assessments on the patient's arrival. Hence, positive incentives to enhance care coordination would affect the rate of readmissions.

From a simple payment approach, the incentives could be structured along the lines of what we characterize as "shared pain," or shared penalties. When a readmission within the observation window for either the discharging or admitting provider occurs, both the referring and receiving provider would have a reduction in payment.

A third idea would be to reduce payment penalties as readmission rates are lowered or eliminate them at a certain threshold point. A final approach would be to start with shared savings and increase the percentage retained by the provider as it decreases its readmissions.

Question 8: The FY 14 President's Budget and MedPAC have both articulated a SNF readmissions program. What are the pros and cons of these approaches?

CMS recently made available its proposed SNF readmissions proposal. AMRPA submitted a comment letter, which is attached at Appendix B.

BUNDLED PAYMENTS

General Comments

AMRPA has examined the concept of bundling in detail, both in terms of bundling acute care services with post-acute care services and bundling multiple forms of post-acute services together. In doing so, we have examined how to establish a bundling program that meets the objectives of payers, reduces burden on participating health care providers, ensures appropriate access to care for beneficiaries, and preserves high quality care in appropriate settings in order to improve patient outcomes. With appropriate consideration and deliberation, a bundling approach can be developed that has the potential to meet the stated goals, namely to improve care and quality while reducing cost. In undertaking this effort, the Committee must ensure that reform of the payment system be undertaken simultaneously with reform of how care is delivered. Regardless of how the program is ultimately implemented, the primary goal of a bundling program should be to improve patient choice, access to services, and health outcomes. Our comments on the various bundling proposals to date, such as the President's, are above. We would also point the Committee to the discussion above regarding the CCH model, which is a bundled payment model that focuses on the needs of the patient. This section discusses more general concerns and responses to the specific questions.

Designing a bundled payment program involves an analysis of many issues. Bundling involves payment to one entity for a defined group of services, which may be supplied by various providers and settings for an episode of care. The entity receiving that single payment (or accountable entity) may be responsible for delivering its own services and managing services and payments for the defined episode of care, which encompasses a period of time and the stated services. The entity would, in theory, have financial incentives to be a more prudent purchaser and user of all health care services covered by the bundle, including outside services, and thus seek to reduce overall health care expenditures.

It is critical that any bundled payment program create incentives to provide high quality care in the appropriate setting in order to improve patient outcomes. It is vitally important in delegating control of an acute and/or post-acute care bundle that CMS avoid providing financial incentives that would jeopardize patient choice and access and lead to inappropriate underutilization of medically necessary rehabilitation services. Even without bundling, patients often are not given full, correct information about post-acute care options, and payers have tried to channel patients into less expensive and less appropriate care settings without any data to support the quality of these settings in terms of outcomes. In fact, it is possible that the recent direction of patients who need rehabilitation services to skilled units of nursing homes rather than IRH/Us has caused the increase in the use of long-term institutionalization in SNFs, an unanticipated more costly outcome leading to higher numbers of re-hospitalizations. A national program must address these problems and seek to avoid exacerbating them.

Persons with disabilities, Medicare beneficiaries, and all patients should have access to clinically appropriate services. If appropriate services are not delivered at all or in a timely manner, there may be increased complications, emergency admissions, and hospital readmissions, which are part of the behavior and increased cost that delivery and payment reforms seek to avoid. This costly effect of bundling would likely reduce or eliminate anticipated savings. Ultimately, payment for services under Medicare must be based on the best interests of the patient. The ideal program will preserve patient choice, align incentives for the patient's benefit, and improve outcomes.

Moreover, any national program must assure the inclusion of the judgment of the physician in determining the appropriate course of treatment for the patient. The physician's judgment in determining the most appropriate post-acute care setting for any patient should be of paramount importance. Most fundamentally, inpatient acute hospital care and inpatient acute medical rehabilitation care are very different. Inpatient acute hospital care addresses the immediate medical condition of patients. It focuses on the pathology and complications of a given diagnosis. Knowing how and when to move patients through the complex post-acute care system is not typically a skill or expertise of most acute care providers. Inpatient acute medical rehabilitation is concerned with improving function, including the ability to walk, talk, and adapt to any residual limitations of these functions, as well as managing the patient's medical status. The primary medical diagnosis or procedure code is not a predictor of post-acute care needs or resource use and should not be used as such in any program.

In order to achieve the goals of improved, efficient care, any bundled payment program should include incentives for all health care providers in the bundle, in particular the accountable entity, to provide high quality care in the most appropriate setting based on the patient's needs with the goal of improving the patient's health outcomes. Acute care providers should be held accountable for the same outcomes for which post-acute care providers are responsible. These outcomes include:

- Preventing harm (*e.g.* minimizing falls, ulcers, infections, etc.);
- Achieving health improvement; (*e.g.* healing ulcers, resolving pneumonia, curing infections, etc.);
- Improving function (*e.g.* demonstrating real and/or potential performance and capacity improvements);
- Meeting or exceeding patient/family expectations (*e.g.* measured through surveys);
- Achieving durable and sustained benefits (*e.g.* avoiding readmissions through successfully managing chronic conditions, continuing to achieve functional gains as an outpatient, etc.); and
- Prudent use of resources (*e.g.* increasing the value of resources spent on care).

Holding entities in the bundle accountable for similar outcomes will ensure objectives are aligned and promote coordination. If payment for an episode of care is contingent on longer-term outcomes, acute

care providers will be incentivized to ensure appropriate post-acute care. If the accountable entity fails to place a patient in the most appropriate post-acute care setting in an effort to cut cost or maintain profit, patient health outcomes could be jeopardized and long-term cost could increase. Therefore, shared accountability, the judgment of a physician, and the adoption of an appropriate assessment tool and quality metrics, are critical to ensuring appropriate placement decisions are made so that care is delivered in the best interest of the patient.

Additionally, it is critically important for the Committee to recognize the bundling efforts that are already underway—and give time for the pilot testing, implementation, and evaluation of these ongoing efforts to occur—before moving forward with new bundling efforts. The ACA included a national pilot project on bundling, which CMMI has implemented as the BPCI initiative. As discussed previously and below, AMRPA has strong concern with the BPCI initiative. Despite its shortcomings, however, it is important to review the program and its outcomes before enacting a second statutory provision on bundling. Congress should let the implementation process for the national pilot project proceed and analyze its results before legislating further on the subject.

Finally, we recommend that any bundled payment proposals embraced by the Committees follow certain guiding principles, which include:

Non-Discrimination in Access and Service

-Any program should assure that there is no discrimination in admission or treatment of vulnerable populations, particularly persons with disabilities.

Patients

-Any program needs to be patient-centered[22] with a focus on restoring health, enhancing function, and returning patients to their homes, schools, jobs, and communities.
-Service delivery should be organized to optimize meeting the needs of patients.
-It must serve the needs of persons with disabilities and chronic conditions in particular, as well as those with acute health problems and assure thereby full access to care. Hence, persons with functional loss must have access to medical rehabilitation and medically complex services that are:
    Focused on prevention of further medical complications; and
    Intended to improve health outcomes, optimize and maintain functional ability, and activity and participation in society, not just survival.
-Any model of change must provide patients with an adequate choice of providers, suppliers, and services.
-Any program should maximize outcomes and patient satisfaction.

Providers

-Appropriate physician involvement, direction, and oversight are key and essential to the delivery of medical rehabilitation and complex medical care.
-Providers should deliver services commensurate with the intensity of service needs of patients.
-Intensity of services received should be provided based on the best available clinical evidence and expert judgment.
-Medical staff organization should have mechanisms for credentialing that assure appropriate physician involvement, direction, and oversight in order to deliver complex medical and medical rehabilitation care.

[22] Patient-centered means the needs of the patient are the primary needs not those of institutions, professionals, payers or governmental programs.

-Providers should be able to receive reasonable payment for delivering high quality care.
-Any program should be designed to maximize innovation and investment in staff infrastructure.
-Providers should be free of regulatory barriers in order to organize the delivery of services to patients in the most effective ways. There must be a level playing field.

Payers

-Cost-effective and cost-efficient care should be promoted.
-Payment must thoroughly account for all payments, costs and resources which reflect the characteristics of patients served, as well as costs not related to patient characteristics.
-The system should maximize administrative simplicity for providers and payers.

Quality

-High quality care should be enhanced, sought, delivered, fairly reimbursed, and maximize patient/family outcomes and satisfaction.
-Reimbursement and measures of success for providers should be risk-adjusted to promote the care of those with the greatest need. Such measures must meet accepted measurement standards. Hence, care must be taken in the design of the pilot to assure that any bias against caring for the hardest cases is removed and that there are no incentives to stint on care or game the payment.
-Risk adjustment will promote treatment for all who need services and not solely those categories of patients whose quality outcomes can be achieved at low cost and therefore who perform well on selected quality measures.
-Quality measures selected should promote positive outcomes, avoidance of adverse events, and demonstrate effectiveness and efficiency of care.

Additional Criteria

-Any program should adjust adequately for environmental factors.
-Any program should encourage an economically rational organization of service capacity.
-Financial risk should be minimized.
-Any program should be sufficiently robust to be replicable as a national program.

Responses to Specific Questions

Question 1: There are various ways to structure PAC bundled payments (*e.g.* PAC only; PAC and inpatient; PAC, inpatient, and physician). What are the pros and cons of each model? Is there an optimal model or are certain models better for different circumstances? Who should manage these payments?

The objective of any bundled payment program should be decided before selecting a payment model. The largest, most comprehensive model of those listed above would be inpatient, physician, and post-acute care, including outpatient and other Part B services. However, moving to this model as a first step runs a very large risk of negative disincentives and patient harm in implementation. There would be a serious question as to how to prevent stinting on care through various strategies or providing unnecessary care. Additionally, bundling service delivery and payment, particularly if the payment is prospective, is a large departure from the current service delivery and payment approach. A bundle that relies on the current payment system may not meet some of the initial objectives of bundling, such as those laid out by MedPAC, if they include more care coordination, better transitions between levels of care, and delivering

clinically-driven care. Under those conditions, unless there are waivers of various regulations, the silos would remain in place along with the multiple regulatory requirements that were established in order to define the silos for various purposes. For many post-acute care providers, (*e.g.* LTCH, IRH/U) the multiple regulations were developed to distinguish them from acute care hospitals for payment purposes first under The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97–248) and then under The Balanced Budget Act of 1997, (P.L. 105–33).

If the objectives include those stated above, we recommend demonstration programs of smaller bundles initially. These would include the hospital-physician bundle. The Acute Care Episode (ACE) demonstration examined this approach. It is important to note that in IRH/Us, there is already extremely close alignment between physicians and hospitals, since rehabilitation care depends so heavily on physicians who are active participants in the care delivery process. Adding physician payments to the rehabilitation hospital payment would change little in the way an IRH/U currently functions. Second, we recommend a demonstration program of post-acute care bundling along the lines of the CCH, which is discussed above. The entity managing the payments can be the acute hospital in the first instance and the CCH in the second instance. Or, in either instance, there may be an external entity that receives, reviews, and pays claims. It could be a convener, insurance company, managed care company, or other type of entity. However, any such entity must demonstrate a history of managing payments in large volume, ability to assess compliance with quality metrics, ability to assure that any criteria put in place to detect and prevent underutilization of care are met and other attributes. Finally, federal policy should retain an option for both post-acute care bundling and bundling that incorporates both acute and post-acute care services. There are many outstanding post-acute care providers in the nation with special capabilities for treating different patient populations. Patients should retain the ability to choose providers, and allowing post-acute bundling would help to keep that option open.

Any bundling model must address a number of issues prior to being implemented. At a minimum, these issues include:

-Defining the bundle: defining the episode of care, defining the scope of services included in the episode of care; type of providers to include; types of patient conditions to include; types of patients to be excluded (*e.g.* brain injury); minimum number of cases to be included;
-Defining the payment method (retrospective, prospective), payment unit and payment amount; address risk adjustment and various payments in addition to those which account for patient care characteristics, such as outliers, wage adjustment, provider adjustments;
-Ethics: assuring access for patients including vulnerable populations; assuring patient choice;
-Data or assessment instrument to collect data across platforms (silos);
-Quality metrics to be used as payment incentives and behavioral governs (*e.g.* ensure no stinting and encourage positive behavior);
-Other protections against stinting and incentives to avoid overutilization of bundles;
-Impact of regional variation in practice patterns;
-Extensive assessment of risk and detailed risk adjustment;
-Statutory and regulatory waivers;
-Cost shifting;
-Coordination of benefits between Medicare and Medicaid;
-Common HIT platforms;
-Attributes, strength and organizational competencies of the accountable entities or entity;
-Patient placement criteria;
-Classification system for the episode of care;

-Cost of the episode of care and potential payment structure (FFS with discount, prospective payment, FFS payment against a benchmark, shared savings, shared loss, bonus for exceeding certain metrics, *e.g.* functional improvement, etc.);
-Care redesign to include navigators, or case managers, enhanced coordination, transitions;
-Readmission reductions; and
-Evaluation criteria for a demonstration before it is scaled up.

Question 2: What are the advantages and disadvantages of the BPCI models as currently proposed by the CMMI?

The advantages of the BPCI is that it is will garner a number of field-initiated approaches to developing episodes of care for specific conditions for specific service bundles given the four models and for specific providers and geographic locations. There are several disadvantages. The BPCI models do not eliminate barriers to siloed delivery of care and siloed treatment philosophies, including the 60% Rule for IRH/Us, the 25 day length of stay requirement for LTCHs, and the 3 day prior hospital stay requirement for SNFs. A separate challenge for bundling post-acute care is that complete freedom of choice of providers limits an entity's ability to manage the care for which the entity is at risk under the bundle. Making the bundle holder take on financial risk only for those patients who stay within a proposed post-acute network of inpatient providers would strengthen the bundling program and provider interest in participating therein.

Because each provider's proposal is unique, it is not clear if any of the final results will be scalable; they should be tested in a broader demonstration before being expanded. A significant number of IRH/Us submitted letters of intent and attempted to participate in the BPCI but could not because of the structure and design of the project, as well as problematic data issues. For example, a number of our members were very interested in the programs; however, when they received the data to analyze in order to file an application, in multiple instances they found that it did not include months of one type of a provider's data (home health), the total number of MS-DRG cases in a designated MS-DRG that were necessary to design an episode based on the MS-DRG (stroke in one instance), or other defects. Hence, they did not apply for Model 3 in particular and in many instances did not apply for Model 2 either because of the difficulties.

As noted above, the BPCI models announced to date are based on fee-for-service payments, plus a discount, to each provider participating in an episode of care with a lead provider, convener, or third party administrator. In the June 2013 Report to Congress, MedPAC advised against using the current fee-for-service payment system with a benchmark for an episode, payment below the benchmark and variants on a bonus / penalty approach. Payment would either go to one entity that would pay all other providers in the episode or payment would go separately to each participating provider, subject to the payment reduction, bonuses, and penalties discussed. Another approach to payment is a prospective payment. Prospective payment for an episode of care can be made only after there is adequate development of a prospective payment system for the episodes of care. Several steps and time are involved in the development of that system; however, it provides the opportunity to waive various regulatory requirements, enhance care coordination and transitions, and achieve other objectives of a bundling program. A third approach is a hybrid wherein during the first several years of a bundle a discounted FFS system with bonus and penalty incentive can be instituted and then after data is collected, analyzed and a new payment system developed, transition to testing the new payment system.

However, no matter what system is chosen (FFS with variants such as bonus/penalty, withhold or shared risk or prospective payment) it must be tied to data reporting and performance on quality measures, including outcomes. The question would be whether total or partial payment should be tied to performance on the quality metrics or only tie quality performance to the receipt of the withhold or shared

savings amount under FFS or bonus/penalty amount under a prospective system. It cannot be overemphasized how important risk adjustment and the use of and performance on quality metrics are in the post-acute care arena where many, if not all, of the populations receiving care are extremely complex, vulnerable, and frail.

Question 3: What additional types of bundled payments should be considered?

We recommend that the CCH, which is included in the ACA at Sections 3023 and 3021 as mentioned above, be considered as a type of bundling payment model. The CCH is a post-acute care model focused on the populations that continue to need institutional level of care after an acute care hospital stay. The episode of care is the CCH stay plus the 30 days following discharge, as stated in the statute. It addresses and includes the levels of service currently found in the IRH/Us, LTCHs, and hospital-based SNFs. It would also involve outpatient therapy services and home health services based on patient needs.

The key elements to be addressed in a CCH, include scope of services, definition of the episode, coordination with existing Medicare benefits package, admission criteria, common patient assessment instrument, and definition of the accountable entity. The definition of the accountable entity should cover at a minimum, licensure, program components, physical space, professional staffing, quality improvement, services provided, staff dedication, ability to deliver or contract for the entire bundle of services, clinical pathways, effective discharge planning and case management, ability to bear risk and understand risk exposure, meet minimum volume standards, meet specific patient care and safety standards, have the necessary financially systems to administer payment across multiple entities, and interoperable HIT and decision support system. It should also have common management, be able to report quality data and measure quality performance on the metrics. Such metrics should act to assure that patients are receiving the intensity of services their conditions require and that there is no stinting of care. Such measures, and measures used in any bundling program, should be relevant to the patient populations, cover a broad scope of medical status and functional ability, be reliable and valid, and be operationally feasible to use. They should be developed to ensure there is coordination with other quality reporting initiatives to limit the administrative burden placed on providers.

The design must also include the payment methodology, which can be implemented in two phases. The first phase would be for the CCH inpatient stay and the second phase would include the complete episode of care (EOC) of the inpatient CCH stay plus 30 days post discharge. The payment system must address risk adjustment to acknowledge patient differences and variability in cost. It can also include outliers, Part B payment other than physician services, address patient co-payments and deductibles, and include special payment adjustments and provider adjustment factors, such as wages, low income percentage, the impact of being rural, and outliers. The payment system also has to address quality incentive payments, case mix adjustment, and payment for services that extend beyond the EOC. Other attributes of the CCH design include a patient classification system, readmissions policy, list of specific statutes and regulations to be waived, and pilot evaluation criteria. If the CCH is virtual, there may be additional considerations as well.

Question 4: What steps need to be taken to protect against stinting or other unintended consequences in a bundled payment initiative?

The potential for underutilization of care (stinting) is a clear downside to bundling of care. However, underutilization is also a dynamic of the current prospective payment systems since many of them involve a fixed payment for a specific payment unit such as at discharge. However, given that a bundled approach has a broader span of services, time, and cost, the incentives to stint on care are increased. Various writers have suggested methods to deter or protect against this practice. They include the following:

1. Quality metrics are critical. The quality measures must be risk adjusted to assure providers that their patient's complexity will not affect their performance on various metrics. This is particularly critical for rehabilitation hospitals and units that treat highly compromised, medically and functionally complex patients. The various measures that could be readily utilized are: mortality, readmissions, visits to the emergency department, discharge to community at the end of the EOC, falls with injuries, pressure ulcers, and once properly developed, functional measures. In addition, the quality metrics should include payment of bonuses/higher incentives for stronger performance on the measures (*e.g.*, pay for performance).

2. Risk adjustment, as noted above, is needed both for payment and quality outcome measurement. It is absolutely critical.

3. Pay the full payment under the current payment system without discounts.

4. Continue with outlier policies that address high cost outliers to help providers mitigate the risk of caring for costly, complex patients, provide incentives to care for such patients, and a cushion in case a patient turns out to be more complex and costly than originally anticipated.

5. Go slowly in implementing any bundled payment by phasing it in over time. The original IPPS used a lengthy transition process and the IRF PPS had a transition period as well.

6. Assure ease in delivery of needed services as an incentive to participate and deliver appropriate services. Therefore, any bundled program should include waivers of currently restrictive regulatory requirements, such as the 25-day stay for LTCHs, three-day stay for SNFs, and 60% Rule for IRH/Us.

7. Institute patient satisfaction measurements/assessments. Patient reports regarding their care may help identify when appropriate care is not being given at all or in an insufficient quantity

8. The definition of the episode of care should be adequately lengthy to ensure appropriate care for individuals with chronic disease and disabling conditions. A 30 day episode is not relevant to the pathophysiology of diseases or conditions such as stroke, traumatic brain injury, spinal cord injury. Providers should have accountability for the longer episode of care.

Question 5: Other than BPCI, how can bundled payments be advanced and tested?

The ACA includes authority to conduct a national bundling pilot and the continuing care hospital pilot in Section 3023, which we have noted above. In addition, Section 3021 includes the CCH as one post-acute model that CMMI can test. In particular, AMRPA recommends that Congress encourage CMMI to implement Section 3023. In addition, other parts of the government that oversee health care services such as the Department of Defense and the Veterans Administration might initiate various levels of bundled payment demonstrations.

Question 6: Should Congress and/ or CMS develop additional bundled payment initiatives prior to implementation and findings from BPCI? If so, how can they be accomplished?

CMS has implemented several initiatives that include various aspects of bundling. These include, for example, the ACE demonstration referenced above, certain aspects of the Accountable Care Organization (ACO) program, and the Medicare Shared Savings Program (MSSP). Several of these programs or

demonstrations are in their early years and, hence, it is too soon to determine their efficacy. At this time, there are a variety of outstanding issues related to the appropriate way to structure a bundled payment. A full list of these issues is outlined in Question 1 above. Given the significant issues to be resolved, we caution the Committees to allow the BPCI and CCH pilots to yield some results before moving forward with either broader or a more permanent bundling program.

Question 7: How can third-party conveners or managers help manage bundled payments?

Conveners can be helpful if they meet specific criteria. For example, a convener should demonstrate a history of managing payments in large volume and the ability to assess compliance with quality metrics. Conveners can also help coordinate providers for or in order to develop virtual bundling entities. The ARA Research Institute, an independent 501(c)(3) charitable organization formed to promote scientific research and education on medical rehabilitation services, is currently proposing to test the CCH as a convener.

Question 8: Should Congress consider establishing virtual bundles that rely upon existing Medicare PAC fee-for-service payments?

For purposes of answering this question, AMRPA assumes that the Committee defines "virtual bundles" as bundling in which there is no bundling organization. In this model, CMS would compare total costs for an episode of care with a target amount. CMS would then scale all providers' payments up or down retrospectively, based on the comparison of actual costs to total costs. In theory, the shared financial risk would offer an incentive for providers to collaborate. However, this collaboration is challenging to accomplish, with some providers having much more power than others to dominate negotiations on collaboration. We urge caution when considering this type of virtual bundles.

AMRPA has developed a different type of virtual bundle within the CCH. As we have noted above, the CCH concept includes inpatient rehabilitation, long-term care hospital services and hospital-based skilled nursing services. At this time, few if any providers throughout the country have a physical location that could provide all three levels of service under the same roof. However, many providers have all three sites of care within a corporate structure or have or could develop contractual relationships among the different sites of care. In developing the CCH, AMRPA recognized that some inpatient rehabilitation hospitals and units might need to contract with a SNF and/or LTCH within a community to implement the CCH. As a result, we think both "real" and "virtual" CCHs hold promise to achieve the objectives of improved care coordination and quality of care that may achieve savings for the Medicare program.

That being said, MedPAC and others have cautioned against using the existing fee-for-service system for bundling. Many of the regulatory requirements of fee-for-service, such as the requirement to provide three hours of therapy a day in an IRH/U, make bundling difficult if not impossible to implement. Maintaining the fee-for-service system maintains the silos of care, which precludes the achievement of the stated goals of bundling namely improved care coordination, quality of care, and cost savings. It is possible to use the existing fee-for-service system in the first year or two years of a bundling demonstration as data are collected and a revised payment and delivery model is devised. However, the ultimate goal should be an innovative payment system that eliminates the silos and eliminates incentives to over or underutilize services for Medicare beneficiaries.

Question 9: What factors should Congress consider when directing the Secretary to establish reimbursement for bundled payments?

A bundled payment methodology must be based on principles that address quality, beneficiary protections, payer policy, and other considerations. We have listed these principles above. Other factors include having payment and cost be equal, plus/minus financial incentives offered, require meeting of performance and outcome metrics(including measures to assure no stinting on care), consider payment adjustments that don't reflect patient characteristics, such as wage adjustments and other adjustments that account for costs that are not reflected in the direct care costs. Several prospective payment systems (IPPS, LTCH, IRF PPS) make such adjustments.

Question 10: How should Congress build-in protections to ensure providers do not induce demand simply because of a bundle's construct (for example, how can Congress ensure that providers are not ordering an inpatient admission just to receive a bundle because an inpatient-PAC bundle may be the highest reimbursed option for a particular condition)?

While overutilization is a valid concern, the greater concern might ultimately prove to be underutilization or stinting on care by the accountable entity in a bundled payment program in an effort to reap a greater profit. In this scenario, the accountable entity would not refer for certain services to avoid having to pay for them. To avoid either underutilization or overutilization, development of appropriate quality metrics and beneficiary protections is critical.

In addition, some of the methods outlined above to prevent stinting could also be used as incentives to prevent excess admissions (*e.g.* risk adjustment, pay for performance, gain sharing, and transition to the new payment system, etc.). Over time, data could be collected to look at patterns of admissions with an eye toward potentially avoidable admissions, which a readmissions policy may help mitigate.

SITE NEUTRAL PAYMENTS

General Concerns

The term site neutral payments is being used to describe numerous situations, be it physician-hospital, ambulatory surgery, or SNF-IRH/Us. This discussion presumes that the objective of any such approach is to make payment based on factors that are unrelated to the setting(s) in which they occur. AMRPA's response focuses on the proposal referred to as "site neutral" in the President's FY 2014 Budget and the August 1 draft legislative language issued by the House Ways and Means Committee in Section 2. AMRPA has great concern with site neutral proposals that would equalize the payment between IRH/Us and SNFs. Site neutral payment policy fails to consider the clinical needs of patients in making decisions about the best course of care. In addition, it does not take into account the fundamental differences in staffing quality, outcomes, and levels of care among post-acute care providers. It also fails to recognize the stringent requirements placed upon IRH/Us that do not apply to other post-acute care providers—there is currently no site neutral regulatory structure.

Question 1: Are some PAC payment settings and/ or conditions more ready for site neutral payment than others?

In order to answer this question, it is necessary to have some criteria against which to judge whether the payment settings or conditions are deemed ready. Unfortunately, the Committee letter does not provide those criteria or a definition. In looking at the SNF/IRH/U proposal referenced above, we find that there

may be some similar conditions treated in each setting, such as certain orthopedic cases and neurological cases. However, the types of services these patients need and their characteristics, in each setting, particularly the neurological cases, are vastly different in terms of care needed and cost. In addition, each site has certain requirements it has to meet in order to participate in the Medicare program, which ultimately have cost implications. SNFs must meet their Conditions of Participation, complete the Minimum Data Set 3.0 for each patient, and file a claim form. IRH/Us must first be licensed as hospitals in their states and meet the Medicare Hospital Conditions of Participation. Second, they must meet the classification criteria found at 42 CFR 412.29 that includes the 60% Rule, which has its own costs associated with it. These also include medical supervision by a physician with specialized training, 24 hour rehabilitation nursing, and a multidisciplinary approach, in addition to the other requirements mentioned. Third, they must meet the medical necessity coverage criteria found at 42 CFR 412.622. Conformance with these extensive regulations is quite expensive and are both more expensive and extensive than those required of SNFs. Then the IRH/Us must complete an inpatient rehabilitation facility patient assessment instrument (IRF PAI) for each patient and submit a claim form. Hence, there are little similarities between the sites and the Medicare requirements they must meet and we believe that neither of these sites are ready for site neutral payment.

Question 2: MedPAC recently articulated a site neutral payment approach between LTCH and Inpatient Prospective Payment System rates. What are the pros and cons of this approach?

AMRPA has no position on site neutral payments between LTCH and IPPS. However, the CCH model described above offers what could be construed to be a site neutral payment approach by neutralizing the sites of care rather than the payments. We encourage the Committee to ensure the CCH model is implemented by CMS.

Question 3: The FY 14 President's budget articulated a site neutral payment approach for selected conditions between IRF and SNF payments. What are the pros and cons to this approach?

The President's proposal would pay SNFs more for certain conditions and IRH/Us less. The payment is calculated based on a payment for a SNF stay and then adds on a percentage of the differentials for overhead and patient care costs. Currently there is no definition of a "SNF stay" because SNFs are paid on a per diem basis rather than a per stay or per patient basis. Hence, this figure does not exist and would have to be constructed.

The presumption behind the IRH/U-SNF site neutral proposal is that it will save funds. This presumption is likely incorrect. First, diagnosis per se is not a predictor of resource use. A patient with the same diagnosis of "hip replacement" as another patient may use a completely different set of resources based on various patient specific factors, including complications and co morbidities, age, amount of therapy delivered, amount of nursing, and the skill mix of the nursing and therapy staff. Additionally, the SNF length of stay has been stated by CMS itself to be 34 days while the IRH/U stay is closer to 13 days. When that number is multiplied by the per diem rate for the type of rehabilitation the patient needed the payment per case would meet or exceed the average payment for lower joint extremity patients in an IRH/U, which was $11, 6690. We presume the per diem rate in the SNFs would be approximately $6,636 for 14 days and $5,400 for 20 days; hence, the SNF stay would be at least $12,036.

Furthermore, the discharge to community rate for SNFs was found to be 45.5 percent by MedPAC, while the discharge rate to community for IRH/Us has consistently been more than 80 percent. MedPAC has found that SNFs are not improving on their quality metrics while at the same time their margins are increasing. SNF Medicare margins are approximately 22-24 percent according to MedPAC, while IRH/U

margins are closer to 9 percent. According to certain analysts, that could be interpreted as IRH/Us devoting more of the cost of their care to patient care than SNFs are, rather than to profit or surplus.

Finally, the readmission rate for the two entities is considerably different. As discussed previously, the readmission rate for SNFs (19 percent) is significantly higher than that for IRH/Us. When readmission costs are added to the SNF stay, the cost of a SNF stay well exceeds that of an IRH/U.

As a matter of equity, narrowing the payment between the two settings would require leveling the regulatory playing field for IRH/Us or SNFs. Currently, IRH/Us have continuing requirements, which are mentioned above, and costs that SNFs do not have. To level the playing field, several IRH/U regulatory requirements should be waived, including the 60% Rule and the 3 hour therapy intensity rule for the patients proposed to be included in this proposal. Alternatively, SNFs should be required to meet the same regulatory requirements that IRH/Us must meet.

Therefore, in the near term, we do not believe this proposal is ready for implementation. We believe more thought should be given to the factors cited above, as well as patients' characteristics, provider or facility characteristics, utilization, and outcomes.

Question 4: MedPAC and the President have proposed near-term policies that move toward site-neutral payment. Are there other near-term site neutral policies that are close to ready for implementation?

The CCH model, as described above, has been authorized by Congress and is ready for implementation. The Committee should ensure the CCH model is implemented by CMS.

Question 5: What criteria should be used to determine if a site-neutral payment is appropriate for a particular condition and for a particular setting?

As noted above, it is challenging to try and predict resource use from diagnosis. Multiple other factors are involved in predicting the cost of a case. These factors include detailed patient characteristics, and the nature, skill mix and type of therapy and nursing services received. In addition, there are costs associated with each setting which stem from the nature of the entity and the numerous state and federal requirements they must meet. Each setting has different cost structures. Unless all settings are subject to similar regulatory requirements, site neutral payments will put more heavily regulated entities, such as IRH/Us, at a perpetual disadvantage.

Question 6: There are two potential ways to approach a site neutral payment: (1) equalizing or (2) narrowing the reimbursement paid for services in two different settings. What are the pros/cons to using these approaches when establishing site neutral payments among PAC settings?

A fundamental principle is that payment should fairly compensate the provider for the cost of delivering the care. Even if two different settings deliver largely the same service at the same "variable" costs, they have numerous fixed costs such as physical plant, infrastructure, licensure, regulatory and accreditation that need to be recognized and incorporated into a payment system. As a consequence it is inherently unfair and unreasonable to equalize payments for two different types of providers.

Question 7: What existing policies are appropriate to consider when determining whether there should be a difference in reimbursement among PAC settings?

The structure and approach of the payment systems being considered for site neutral payments should be examined for similarities and differences. The IRH/U IRF PPS is based on individual patient characteristics, provider characteristics, and a general need to reflect the needs of the patients' health and outcomes. The SNF PPS is based on the observed or predicted amount of therapy a patient may require and other resource use, very few patient specific characteristics and limited facility characteristics. Hence, the two are very different. If the focus of site neutral payments is to save Medicare expenditures, we suggest that the IRF – SNF proposal would need to be extensively reexamined and rethought in order to do so. At this point, we do not believe it will save the funds that are envisioned when one looks at the entire cost of care for patients served in each setting.

OTHER QUESTIONS RAISED BY ALTERNATIVE FEE-FOR-SERVICE PAYMENT

Question 1: What, if any, is the ongoing role for FFS as we move toward post-acute care reform? What percentage of reimbursement needs to be put at risk within the various types of reforms outlined in your comments to incentivize participation in alternatives to FFS? Who should manage these patients?

If the objective of post-acute care reform is to move away from FFS, a transition period should be included for each type of provider. The transition period for each provider may vary based on a number of factors. For example, these transitions can be based around various incentives, including quality performance on specific metrics, simple percentage discounts, shared savings models, or shared savings in future years once comparative data is collected.

Each provider can manage its own patients against the quality metrics established. However, the entity responsible for managing will depend upon the nature of the reform. We have recommended above the implementation of the CCH pilot, with the CCH managing the patients. We have also outlined the attributes of the accountable entity for both managing the payments and patients and refer the Committees to the discussion above.

FFS payment models are closely linked to freedom of choice for beneficiaries. It is unrealistic to expect that providers can exert high degrees of control over patients without resorting to potentially unethical and deceptive practices to "channel" patients into accepting the care providers and settings desired by the provider. Patients must experience economic incentives to partner with providers in selecting the care providers and pathways being sought and to diminish the perception of "entitlements" inherent in the current Medicare post-acute care benefit structure.

Question 2: What patient and facility level data may be needed to design any of the systems discussed above?

At a minimum, there should be patient data collected on a standardized data assessment tool as well as current patient assessment instruments while systems are being designed. In addition, all claims data should be collected as well as any additional payment and cost reporting data. Data should include FFS and Medicare Advantage beneficiaries. Finally, resource use data and utilization data should be collected across all settings.

Question 3: What types of transitions may be needed in moving to any of the systems discussed above?

We appreciate the Committees' recognition that transitioning to any new payment system will be critical. Providers will need time to modify hardware and software, such as billing software or electronic health records systems. In addition, internal documentation processes and staff and physician training will be required. If the reformed post-acute care payment system involves a greater degree of care coordination, providers will need to establish processes that allow for the sharing of information, including interoperable health record systems and even legal agreements that protect the confidentiality of patient information. MedPAC and stakeholders have stated that such a transition could take a minimum of four to five years.

For example, when Congress and CMS first moved to a prospective payment system for inpatient acute care hospitals, ultimately known as the IPPS, capital costs were not initially included and payment was based solely on operating costs. Hospitals transitioned to this first phase of the IPPS over a number of years. Ultimately, capital costs were folded into the payment under the IPPS and diagnosis-related groups (DRGs) were developed to further define payment to hospitals based on the typical services received by categories of patients. The DRGs continue to evolve as the practice of medicine advances and new products and services become available to treat patients; allowing patients with certain conditions to live when at one time such patients might have died. Hence, a transition to a new post-acute care payment and delivery model should occur over a realistic transition period and be reviewed periodically as changes may occur over time.

Question 4: These new payment systems may pose questions for existing policies (PAC transfer policy, 3-day hospital stay, etc.) and program integrity measures (anti-kickback, anti-trust, etc.) that were developed in the FFS context. Do these existing policies and program integrity measures need to be modified to operate in PAC reform world? If so, how? To what extent are providers willing to take more financial risk if more of these policies can be altered?

Existing Policies

If Congress and CMS are serious about post-acute payment reform, there must be a concurrent commitment to ensure that the regulatory burdens are modified to accommodate the reform purposes. In testing and/or potentially implementing a bundled and/or site neutral payment policy of any sort, existing policies and regulations clearly would need to be eliminated or modified under new payment systems, including existing Conditions of Participation.

CMS must be willing to grant the broadest possible waivers for regulatory relief. For example, when a provider that participates in Medicare under one method of delivery is actually delivering services as if it was classified as a different type of provider, and is accepting payments as that provider type, the entity does not jeopardize its operations or underlying financial stability by experiencing participation problems or payment problems.

Depending on the scope and participants in any post-acute care reform, a number of existing regulatory policies would likely need to be modified. As noted previously, IRH/Us are subject to stringent regulatory criteria that simply are not required of other post-acute care providers. Many of these criteria would likely need to be modified as a result of post-acute care reform. For example, if the Secretary were to implement the CCH described above, the Secretary would need to waive the following preliminary list of regulatory requirements:

- Conditions of participation for IRH/U, SNF, LTCH;
- IRF Classification Criteria – "60% Rule" (42 CFR § 412.29);
- Coverage – "3 Hour Therapy Rule" – (42 CFR § 412.622(a)(3)(ii));
- "25 Day" Average Length of Stay Requirement for LTCH – (42 CFR § 412.23(e));
- Restriction on Location of Freestanding LTCHS known as "250 Yard Rule" – (42 CFR §§ 412.23(e)(5) and 413.65);
- Transfers between Co-Located Providers – (42 CFR § 412.22(e));
- Hospital-Within-Hospital Rules (42 CFR § 412.22(e));
- "25 Percent Rule" – (42 CFR § 412.534);
- SNF "3 Day" Rule and Transfer Rule (42 CFR § 409.30);
- Swing Bed Facilities (SSA § 1888(e)(7));
- Certain Home Health regulatory policies, such as the Face-to-Face Encounter requirement;
- Exemption from Recovery Audit and Medical Necessity reviews;
- Federal and State Quality Rating Systems; and
- Request for State waiver approvals: With regard to licensure, the State would need to affirm that it has no problems with the licensed facility operating as a different type of licensed operation.

Program Integrity

Additionally, AMRPA has long called for improvements in program integrity measures that would strengthen the Medicare program while reducing burden on providers. As discussed more fully below, AMRPA recommends that to improve federal fraud, waste, and abuse efforts, Congress should consolidate contractors, establish a contractor clearinghouse, limit records requests, penalize inefficient and inaccurate contractors, and ensure qualified reviewers.

In the last decade, Congress and the Administration have created multiple entities designed to combat fraud and abuse in the Medicare and Medicaid programs.[23] While the creation of these entities was rooted in the justifiable desire to protect Medicare and Medicaid resources and beneficiaries, they have failed to protect the programs' resources while burdening patients and providers.

Medicare fraud, waste, and abuse contractors have been exceptionally active denying claims for various, often confusing, reasons. These denials are ultimately overturned in the vast majority of cases. AMRPA's eRehabData® appeals tracking system shows that from 2005 to the present, slightly more than 85 percent of all denials were reversed by an Administrative Law Judge (ALJ). These denials, and the resulting appeals process that providers must undertake, impose significant burdens on providers. The traditional appeals process has four steps before a provider can appeal to a federal District Court. As a result, providers must slowly wind their way through the appeals process in a costly exercise that can take 18-24 months. For example, it is the experience of rehabilitation providers that the cost of an appeal is often $5,000 or higher per claim.

Some of the burdens originate in misaligned incentives built into the payment structures of certain contractors. Contractors have built in incentives to improperly deny legitimate claims for the sake of maximizing the contractor's own profit. The incentives to identify "overpayments"—even those that are later overturned—are demonstrated by recent analysis of CMS data. Although Recovery Audit Contractors (RACs) are authorized to identify and correct underpayments to providers, the clear focus of

[23] *E.g.,* Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), Program Integrity Contractors such as Program Safeguard Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs), and Medicaid Integrity Contractors (MICs).

these contractors is on the identification of overpayments. According to a CMS report analyzing the first quarter 2012 results of RAC activities, RACs found a total of $588.4 million in overpayments but only $61.5 million in underpayments.

Unfortunately, these administrative costs and burdens ultimately impact patient care. Clinical staff working on defending denials may be taken away from their direct patient care responsibilities to respond to voluminous and redundant documentation requests from multiple contractors. Additionally, providers may be hesitant to admit certain categories of clinical cases if these categories are subject to close to 100 percent review, no matter how successful the outcome of the final appeal.

Addressing these issues can be accomplished in a way that maintains the focus on preventing fraud, while lessening burdens on providers and patients. Specifically, Congress can take the following actions to ensure fraud, waste, and abuse funds are being used effectively:

- Consolidate the number of Medicare compliance contractors, including claims processing and program integrity contractors, and clarify each contractor's responsibility, scope of authority to request records, and ability to deny payments;

- Establish a government-wide clearinghouse that coordinates the activities of these contractors, including all requests for records;

- Create reasonable absolute numbers of records that can be requested in any 60-day period and revise additional documentation request (ADR) limits;

- Increase transparency regarding the sources contractors use when adjudicating provider claims. When CMS contractors use proprietary, subscription-based services that interpret or reinterpret Medicare coverage and admission policies for purposes of making their own coverage or medical necessity determinations, they should be required to release those materials to the providers against whom those materials are used;

- Prohibit contingency payments to RACs and any other contractors seeking to identify and collect overpayments to eliminate the perverse incentives to deny claims inappropriately;

- Penalize contractors that trigger overpayment demands or denials that are overturned at high rates;

- Subject cases that MACs identify for review to prior authorization. Providers who demonstrate a high degree of accuracy over time could ultimately be able to attest, without pre-authorization, that the services billed meet Medicare coverage guidelines;

- Assure that compliance contractors and others reviewing appeal requests utilize appropriately qualified staff;

- Require entities reviewing these appeals to issue decisions in a timely fashion to prevent lengthy and unnecessary delays in the resolution of these appeals;

- Ensure that contractors define the specific basis for denials, especially medical necessity in the context of rehabilitation;

- Delay the authority to recoup funds for "overpayments" from the time of the decision of the Qualified Independent Contractor (QIC) to the time of the decision of the Administrative Law Judge (ALJ). Returning overpayments at the QIC level, as is now required while a decision is pending at the ALJ level, places a significant financial hardship on IRH/Us;

- Fund additional ALJs to accommodate the influx of appeals from RAC, MAC, and other contractor decisions. These new positions could be funded by applying a portion of the contingency fees that RACs must repay CMS for claims reversed though the administrative appeals process;

- Eliminate the "Qualified Independent Contractor" (QIC) level of review. Widespread experience of providers suggests the QIC level of review is simply a bureaucratic delay in the appeals process where very few cases receive a meaningful medical review;

- Approve legislation already introduced in the House of Representatives (H.R. 1250) to modify the RAC program and overturn the Palomar Decision. This would permit providers to seek enforcement of the regulatory time limit (i.e., four years) for reopening Medicare claims without good cause, thereby protecting providers from reopening of old claims for no justifiable reason; and

- Impose "Medical Inference Standard" on CERT contractors. Under this standard, CERTs and other Medicare contractors would be required to take into consideration the totality of the documents in the patient's file, and make reasonable medical inferences based on the totality of the circumstances before rendering judgment as to the appropriateness of the claim.

False Claims Act Reforms

In addition, Congress should make certain revisions to False Claims Act liability as part of any post-acute care reform. Specifically, providers with pending appeals should not be subject to false claims act liability as a result of the ACA's "60 Day Repayment Rule."

ACA requires a provider to report and repay overpayments or face potential False Claims Act liability. Unfortunately, the provision does not address how this requirement interacts with the appeals process for providers contesting a contractor's decision to reject a claim. Congress and CMS should make clear that providers appealing a denied claim are not subject to the 60 day reporting requirement until the conclusion of the appeals process.

Under current practice, if a contractor reviews and then denies a claim, it issues a demand letter for the repayment. The provider may then respond in one of three ways: (1) repay the claim; (2) seek to have repayment delayed while it pursues the appeals process; or (3) follow the traditional appeals process and repay the claim. The traditional appeals process allows for a review of the contractor's decision to deny the claim. However, the process is extremely time-consuming. The appeals process involves five phases and can take well over a year.

AMRPA is concerned that Section 6402(a) of the ACA may cause problems for providers seeking to pursue the appeals process. Section 6402(a) requires a person who has received an overpayment to report and return the overpayment within 60 days of its identification. On February 16, 2012, CMS published in the *Federal Register* a proposed rule entitled "Medicare Program: Reporting and Returning of Overpayments" implementing this requirement. The proposed rule does not acknowledge nor address the

relationship among the appeals process, the recoupment process, and the requirement to repay overpayments within 60 days. The proposed rule does not specify whether the potential overpayment in question is to be identified by the provider or the contractor. If identified by the contractor, the 60 day window to repay to avoid a false claims determination does not appear to take into consideration provider appeal rights.

This presents providers with a difficult decision. The provider may wait to repay a potential overpayment until the appeals process is exhausted but in so doing risk additional penalties for filing a false claim for failure to repay these funds within 60 days. Alternately, the provider could repay the funds while simultaneously appealing and wait to be reimbursed if the denial is subsequently overturned during the appeals process. While we recognize overpayments should be returned in a timely fashion, providers should clearly have the ability to challenge denials and overpayment demands, using well-established administrative mechanisms, without fear of False Claims Act liability.

The proposed rule also authorizes a ten year look-back period which subjects any claim submitted within the last ten years to the 60 day repayment period. If finalized, the look-back period would create a significant administrative burden for providers. A provider could be required to review all claims from the last ten years of the type that a MAC or RAC is reviewing to ensure an overpayment was not received.

To ensure that providers do not face inappropriate False Claims Act liability, Congress and CMS should:

- Make the appeals and recoupment processes available to providers prior to having to repay a claims that may fall within the scope of Section 6402 (a) of the ACA;

- One approach is for CMS to address this concern in the definitions of "identification" and "reconciliation" in the final rule implementing this provision. These terms must be defined in such a way that a provider could avail itself of the recoupment and appeals processes and essentially stay repayment of the claim until the appeals process is exhausted; and

- Continue to monitor the response rate of the entity responsible for reviewing appeals at each level to guarantee that decisions are issued within the specified timeframes of the appeals process.

Other Contractor Reform

AMRPA remains very concerned that the various contractors often overzealously search for minute, technical reasons to deny claims rather than concentrating on uncovering actual fraudulent activity. AMRPA recognizes that full and complete documentation of the patient's status and of the medical record is critical to assuring proper care for medical rehabilitation patients, starting with the point of referral and the preadmissions screening. In addition, AMRPA appreciates that payers can establish reasonable documentation requirements to ensure payment for services is appropriate. However, strict and completely rigid attention to the technical aspects of this documentation creates an unnecessary burden for providers and an inappropriate barrier for patients, as providers are forced to spend time and effort meeting detailed contractor requirements.

AMRPA believes that in reviewing claims these technical aspects should be considered secondary to the overall clinical assessment and the needs of the patient. For example, denials have been issued for missing deadlines by as little as an hour. Rehabilitation providers are required to perform a post-admission evaluation within 24 hours of the patient's admission to the IRH/U. AMRPA has learned that contractors have denied claims if the physician signature was provided an hour late, even if the evaluation demonstrated that a patient needed an inpatient rehabilitation level of care. It appears that contractors are

focusing on technical requirements and overlooking the clinical judgment of the physician and the needs of the patient.

To improve the efficiency of federal fraud, waste, and abuse efforts, Congress should ensure that contractors are focused upon providers with a history of non-compliance, not providers who have made minor, technical mistakes. Congress should work to:

- Create a "non-compliance threshold" that withholds payment to consistently non-compliant providers while not penalizing providers for non-routine, technical mistakes;
    - For example, a threshold might be set that denies payment for exceeding time requirements by more than 20 percent of the standard, or denies payment when a recurring pattern of non-compliance is observed during an audit (more than 30 percent of the records reviewed, for example); and

- Establish a "medical judgment" standard that recognizes the responsibility and authority of the physician to make medical determinations. As part of this standard, establish a physician "compliance rate" such that contractors only deny payments when a certain threshold of denied claims is reached.

Question 5: Are there existing policies that must remain in place when FFS payment still exists?

If fee-for-service payment continues to exist within an unreformed post-acute care sector, it is important that the classification and coverage requirements that distinguish IRH/Us and SNFs remain in place and that reimbursement appropriately accounts for these differences.

As noted, Medicare requirements for IRH/Us are stringent and different from other post-acute care providers. To be classified as an IRH/U, the hospital must have medical directors and nurses who specialize in rehabilitation, have 60 percent of admissions come from 13 specific diagnoses, and can only admit patients who can sustain 3 hours of therapy a day, and have the potential to meet predetermined goals. Other post-acute care providers, such as SNFs, are not required to meet similar requirements. As discussed above, reform of the post-acute care system should break down silos between providers, allowing the patient to obtain the appropriate level of care at the appropriate site. However, until reform is accomplished, the requirements above help to distinguish IRH/Us from other non-hospital providers. IRH/Us provide hospital-level, intensive inpatient rehabilitation, and IRH/U classification and coverage requirements are indicative of this fact.

Because IRH/Us provide hospital-level care, Medicare must reimburse IRH/Us commensurately with the high level of care they provide. As discussed more fully above, under no circumstance should Congress implement a "site neutral" policy under which IRH/Us and SNFs are reimbursed at the same level. A proposal to establish "site neutral" payments ignores the IRH/U physician, nursing, hospital infrastructure and related costs that are not covered by SNF rates or required of SNFs. Thus, any payment differential between SNFs and IRH/Us should remain in place while FFS payment still exists and beyond.

BUDGETARY IMPLICATIONS

Question 1: How will payment reforms lower federal spending, and to what extent? What types of efficiencies can be expected?

As discussed previously, AMRPA is concerned about potential additional Medicare and Medicaid cuts to IRH/Us in any post-acute care reform proposal. The Committee must ensure that reform is not used as a stalking horse to implement payment cuts that will harm patient care. Additionally, the Committee must look closely at whether promised "efficiencies," such as site neutral payments will in fact produce any expected savings. Instead of focusing on IRH/Us, a sector in which there has been little growth, Congress should take the opportunity to examine those sites of care with large and growing margins. In short, any payment reforms should focus on areas in which significant growth and spending problems exist, and take into account the history of payment cuts that IRH/Us have faced.

A. Growth and Spending Concerns Are Minimal in IRH/Us

Medical rehabilitation is a critical component of the health care delivery system that prevents unnecessary medical costs in the long-term and allows patients to return to their homes, work, and community. Unlike other post-acute care providers that have experienced explosive growth, rehabilitation hospitals and units have seen overall declines in utilization over the past eight years.

Since 2003, IRH/Us have had the lowest Medicare spending growth of any post-acute care provider and growth has been negative in three of the last five years.[24] Analysis of eRehabData® shows that the total number of annual Medicare admissions has declined since the third quarter of 2003 by nearly 155,000 patients, shrinking capacity exactly when the large wave of American baby boomers will be placing increased demand for services on the field. A recent Moran Company analysis demonstrated that Medicare IRH/U volume in the second quarter of 2012 is down 24.4 percent from the comparable period in the second quarter of 2004.

MedPAC's March 2013 Report to Congress paints a picture of a sector in a modest state. It stated that the supply of IRH/Us has been declining since 2005 and decreased by 35,250 beds in 2011. Overall, among freestanding facilities, nonprofit IRH/Us, and hospital-based units, the supply of IRH/Us is relatively stable. MedPAC noted that the volume of Medicare FFS beneficiaries treated in IRFs remained relatively stable in 2010, but MedPAC's March 2013 Report finds that the aggregate supply of IRFs continued to decline in 2011.

Any cuts to IRH/Us will reverse this recent, limited progress. Cuts would be especially damaging to small and hospital-based IRH/Us. Facilities with less than 21 beds and hospital-based units faced negative margins in 2011.[25] Rehabilitation hospitals and units cannot absorb additional payment reductions without adversely affecting patient access.

B. Other Post-Acute Care Sectors have Experienced Substantial, Consistent Growth

When considering the budgetary implications of post-acute care reform, Congress should consider the margins and growth of post-acute care providers. According to MedPAC, average Medicare margins for SNFs range from 22-24 percent, while margins for home health are, on average, 14.8 percent.[26] These

[24] MedPAC June 2012 Data Book (Chart 8-2).
[25] MedPAC March 2013 Report to Congress.
[26] MedPAC March 2013 Report to Congress.

double-digit margins contrast significantly with the estimated IRH/U margins of 9.6 percent. This also means that IRH/Us spend more of each Medicare dollar on patient care than home health agencies and SNFs.

In addition to margins, spending on IRH/Us has stagnated while spending in other post-acute care sectors has soared. According to MedPAC, Medicare spending on IRH/Us was $6.46 billion in 2011, nearly identical to 2004 spending levels.[27] This has occurred even as spending on nursing home care and home health has more than doubled.

C. Any Payment Reductions Must Take Into Account—and Give Credit for—Recently-Enacted Spending Cuts to IRH/Us.

If Congress were to consider changes that reduce funding for post-acute care services, it should apply a standard of equitable fairness and take into account recent, significant cuts already imposed on the IRH/U sector and give credit for those reductions in its policymaking.

Congress already enacted significant IRH/U cuts in recent years, many of which are on a trajectory of additional cuts that will continue to impact IRH/Us on an annual basis. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) cut IRH/Us by $4 billion over ten years. MMSEA froze the IRH/U market basket update at 0 percent from April 1, 2008 through the end of Fiscal Year 2009 — six full quarters without an update. This significant cut helped to pay for a number of unrelated priorities in the bill.

The ACA subjected inpatient hospitals, long-term care hospitals, IRH/Us, psychiatric hospitals, and outpatient hospitals to across-the-board cuts totaling $156.6 billion over 10 years. These cuts included annual reductions to the IRH/U market basket through 2019. It should be noted that SNFs and home health escaped the trajectory of ten year annual cuts the ACA imposed on hospitals (including IRFs and LTCHs). These market basket cuts increase each year. In addition, the ACA included an annual productivity adjustment that, when combined with the market basket cuts discussed above, will significantly reduce or eliminate the market basket update for IRH/Us.

Additionally, the Budget Control Act of 2011 included a 2 percent sequestration cut to Medicare payments. The cut is significant because, on average, 60 percent of patients in IRH/Us are Medicare beneficiaries.

AMRPA strongly objects to any further cuts to IRH/U payments as they will further jeopardize access to care for Medicare beneficiaries (and all other patients) and individuals with disabilities. These vulnerable populations should not be expected to shoulder the burden of reducing the deficit or offsetting the cost of the Medicare physician fee fix. Any proposal developed by Congress should recognize the significant and ongoing cuts to IRH/Us.

D. Should Congress Attempt to Reduce Spending in the Post-Acute Sector, it Should Focus on Existing Proposals that Address High-Margin Sectors

Should Congress attempt to reduce spending in post-acute care, it should utilize existing proposals that target spending reductions to those providers with the greatest margins and growth. As discussed above, growth and margins within the SNF and home health sector are significant. Many entities, including the Simpson-Bowles Commissions, the Congressional Budget Office, the Office of Management and Budget,

[27] MedPAC March 2013 Report to Congress.

MedPAC, HHS, the National Coalition on Health Care, UnitedHealth, and the Center for American Progress, have released proposals to reform payment policies in post-acute care sectors. Congress should look to these proposals for guidance in addressing the growth and margin concerns in SNFs and home health. For your convenience, we have included a summary of these recommendations in Appendix C.

BENEFICIARY PROTECTIONS AND ISSUES

Question 1: If Congress alters incentives, what steps are needed to ensure that beneficiaries are protected and receive care in the appropriate setting?

As noted in our principles, it is critical that payment reform creates incentives to provide high quality care in appropriate settings in order to improve patient outcomes. It is equally clear that financial incentives drive behavior. It is critically important to ensure that the development of alternative payment and delivery methodologies avoid providing financial disincentives that would jeopardize patient choice, access, and lead to inappropriate underutilization of medically necessary rehabilitation services. In our current payment system, patients often are not given full, correct information about post-acute care options. Payers have tried to channel patients into less expensive and less appropriate care settings without any data to support the equality of these setting in terms of outcomes. In fact, it is possible that the recent direction of patients who need rehabilitation services to skilled units of nursing homes rather than IRH/Us has caused the increase in the use of long-term institutionalization in nursing homes. This will produce an unanticipated more costly outcome, as well as a measurable increase in readmissions. Payment reform must address these problems and seek to avoid exacerbating them.

Persons with disabilities, Medicare beneficiaries, and all patients should have access to clinically appropriate services. If appropriate services are not delivered at all or in a timely manner, there may be increased complications, emergency admissions, hospital readmissions, and excessive long-term unnecessary institutionalizations. This costly effect of delayed access to appropriate care would likely reduce or eliminate the anticipated savings of payment reform.

Moreover, the payment system must assure the inclusion of physician judgment in determining the appropriate patient course of treatment. The physician's judgment in determining the most appropriate post-acute care setting for any patient should be of paramount importance. Most fundamentally, inpatient acute hospital care and inpatient acute medical rehabilitation care are very different. Inpatient acute hospital care addresses the immediate medical condition of patients. It focuses on the pathology and complications of a given diagnosis, including resolving the immediate, if not emergent, situation and moving the patient to the next level of care. Knowing how and when to move patients through the complex post-acute care system is not typically a skill level or expertise of most acute care providers and physicians. Inpatient acute medical rehabilitation is concerned with improving function, including the ability to walk, talk, and adapt to any residual limitations of these functions, as well as managing the patient's medical status. The primary medical diagnosis or procedure code is not a predictor of post-acute care needs or resource use and should not be used as such in any new payment system. The primary diagnosis or procedure may be resolved and there may be residual or new conditions or deficits to be addressed in the post-acute care setting.

Ultimately, payment for services under Medicare must be based on the best interests of the patient. The ideal payment system will preserve patient choice, align incentives for the patient's benefit, and improve outcomes. In addition, to the selection of appropriate quality measures, there needs to be agreement on the specific items, perhaps through a consensus panel of experts, for all post-acute care prior to any further steps being taken.

Question 2: How should issues of beneficiary preference be accommodated (*e.g.*, preference for a provider closer to home/family)?

Congress should require that the Secretary assure there is adequate choice of providers for patients. AMRPA is extremely concerned that there be conditions of qualification that require all providers in a reformed payment system to demonstrate how they will assure that patients have choice in selecting their care providers and that they are made aware of any financial arrangements among the participating providers. Patients needing intense medical rehabilitation services must be able to choose their providers for these services. For example, AMRPA is concerned that bundling poses an extra dilemma for the bundle holder in providing appropriate care in the community for beneficiaries and a strong incentive inherent in the program to withhold or stint on care.

In addition, we are concerned that bundle holders would refer patients only to providers in the bundle holder's network and seek to penalize them for making choices outside the networks. Additionally, some conditions may be so specialized or geographically distinct that they should be outside any payment system.

AMRPA recommends that:

a. Patient participation in any payment reform initiatives, such as accountable care or bundling, should be transparent. Patients should have the choice to participate in the network. If they choose to participate, they should retain the right to choose their providers within the network. Hence, if the discharge plan is to send them to a SNF and they or their family believes that an IRH/U or LTCH is more appropriate they should be able to make that choice.

b. If patients are automatically enrolled in a payment reform demonstration or new payment system, they must be informed and retain the right i) to opt out of receiving services through the demonstration, as well as retain the choice to select providers outside the demonstration, and ii) retain the right to choose the providers within the demonstration.

c. Patients retain all appeal rights they have regarding discharge from acute care hospitals, post-acute placement, and all others. These appeal rights must be clearly stated.

d. The relationships of all participating providers must be transparent to the patients.

Question 3: What steps need to be taken so that payment reform does not create incentives to avoid certain patients or inappropriately reduce care?

As noted above, AMRPA is committed to ensuring any reformed payment system prevents "cherry-picking" healthy, low-cost patients and stinting on care for patients with high-cost, high-resource needs. Bundling is one method of payment reform under consideration by this Committee and other policymakers. AMRPA is concerned about what entity will be the "bundle holder," also referred to as the accountable entity. If it were to be the acute care hospital, a physician group, a physician, a hospital organization, or an entity comprised of a hospital, a physician group, a SNF and a home health agency as mentioned in the statute, there is still concern regarding the level of understanding and expertise present to provide the proper level of inpatient rehabilitation care. To prevent "cherry picking," we recommend the new payment system include quality measures and changes in the quality score. In addition, the payment

system should track changes in the number of referrals to and from acute care, to and from post-acute care, and physician referrals prior to and after implementation of the new payment system.

Question 4: How should beneficiary cost-sharing be addressed in any new PAC payment system, including site neutral, bundling, and others addressed in this letter?

At this time, CMS is engaging in a variety of payment reform demonstrations, such as accountable care organizations and the Medicare Shared Savings Programs, which may allow beneficiaries to share in savings achieved by providers. In addition, private insurers have developed a variety of cost-sharing mechanisms, such as a higher deductible and/or co-payment for using out-of-network providers and lower cost-sharing for beneficiaries that participate in programs to help them stop smoking, control their diabetes, or lower their blood pressure.

Question 5: Are there mechanisms other than cost-sharing to encourage Medicare beneficiaries to more appropriately select PAC services?

We believe beneficiary education as to what each type of provider does and what criteria they must meet to bill the Medicare program would be beneficial. Also, patients need additional information about what a provider's quality score truly means and ways to determine if a provider has better outcomes when compared to others. In addition, a quality program that cannot be "gamed" and elimination of the silos could lead to improvements in care and care coordination.

V. Conclusion

Thank you for the opportunity to provide comments on this important issue. AMRPA looks forward to working with the Committee to reform the post-acute care system and ensure patients continue to have access to medically-necessary medical rehabilitation care. If you have any questions about these recommendations, please contact Carolyn Zollar (czollar@amrpa.org) at 202-223-1920 or Martha Kendrick (mkendrick@pattonboggs.com) at 202-457-6520.

Sincerely,

Marsha Lommel, MA, MBA, FACHE
President and Chief Executive Officer
Madonna Rehabilitation Hospital
Chair
AMRPA Board of Directors

Index of Appendices

Appendix A
AMRPA Suggested Revisions to the CARE Tool

NOTE: As you review this draft, you will notice different colors of text. These are used to help identify the source. The color code used includes:

Black = headers, instructions, etc.
Brown = from the CARE Tool
Blue = from the ICF, ICD-10 book
Green = from other existing tools (referenced) such as FIM/FAM
Red = field developed
Purple = Questions

Signatures of Clinicians who Completed a Portion of the Accompanying Assessment

I certify, to the best of my knowledge, the information in this assessment is:

- An accurate and truthful reflection of assessment information for this patient,
- Based on data collection occurring on the dates specified and
- Data-entered accurately.

	Printed Name	Credential	License #	Sections Completed	Date(s) of Collection
Ex.	Mary Smith	RN	12345	Body Function	MM/DD/YYYY
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

I. Administrative Items

A. Assessment Type MRN_____

_____ Reason for assessment: (1) Admission (2) Interim (3) Discharge (4) Expired

____/_____/_____ The last day of the admission assessment period
MM DD YYYY

B. Provider Name _____

C. Patient Information:

First Name_____ Middle Initial _____ Last Name_____

Admission Date _____/____/_____ Date of Birth _____/____/_____
MM DD YYYY MM DD YYYY

SSN (optional)_____ Medicaid #_____

_____Gender (1) Male (2) Female _____ Zip Code

_____Is English primary language? (1) Yes (0) No If no, what is primary language? _____

_____Does the patient want or need an interpreter (oral or sign language)? (1) Yes (0) No

Race/Ethnicity – Check all that apply:
□ American Indian or Alaskan Native
□ Asian
□ Black or African American
□ Hispanic or Latino
□ Native Hawaiian or Pacific Islander
□ White
□ Unknown

D. Payer Information: Current Payment Source(s):

□ (1) None
□ (2) Medicare – traditional FFS
□ (3) Medicare – managed care
□ (4) Medicaid – traditional FFS
□ (5) Medicaid – managed care
□ (6) Worker's Compensation
□ (7) Title Programs (e.g. Title III, V, or XX)
□ (8) Other government (e.g. TriCare, VA, etc)
□ (9) Private insurance/Medigap
□ (10) Private managed care
□ (11) Self-pay
□ (12) Other (specify)_____
□ (13) Unknown

II. Admission Information

A. Pre-admission Service Use

____ Admitted from:
(1) Acute Care Hospital
(2) Long Term Acute Care Hospital
(3) Inpatient Rehab Facility
(4) Skilled Nursing Facility
(5) Long Term Nursing Facility
(6) Psychiatric Hospital/Unit
(7) Hospital Emergency Room
(8) Community Residential Setting
(9) Other (e.g. transfer between units in an acute care setting)

In the last 2 months, what other medical services besides those identified (left) has the patient used? (Check all that apply)

□ Acute Care Hospital
□ Long Term Acute Care Hospital
□ Inpatient Rehab Facility
□ Skilled Nursing Facility
□ Psychiatric Hospital or Unit
□ Home Health Agency
□ Hospice
□ Outpatient Services
□ None

If patient was admitted from a medical setting, what was the primary diagnosis being treated there?

_____

Within the Acute Care Hospital Stay, on what other units was the patient treated prior to coming to this unit? Check all that apply.

□ Critical Care/Intensive Care (1-2 pt/RN
□ Step-Down/Intermediate Care (3-6 pt/RN)
□ General Medical (>6pt/RN)
□ No previous units or NA

B. Patient History Prior to the Current Illness, Exacerbation or Injury

_____ Prior to this recent illness, where did the patient live?

□ (1) Private Residence
□ (2) Community Based Residence (e.g. Assisted Living)
□ (3) Long term care facility
□ (4) Other (e.g. shelter, jail, homeless)
□ (5) Unknown

If the patient lived in the community prior to this illness: (skip if scored 3-5 above)

Who did the patient live with?

□ Lives alone
□ Lives with Spouse
□ Lives with Parents
□ Lives with Siblings or other family
□ Lives with others (specify) _____
□ Lives with paid helper
□ Unknown

What help was used?

□ No help received or necessary
□ Unpaid assistance
□ Paid assistance
□ Unknown

Are there any structural barriers in the patient's residence that could interfere with discharge?

□ None □ Stairs inside the dwelling that are necessary □ Stairs enter/exit residence
□ Narrow doorways □ Inaccessible Bathroom □ No space for extra equipment
□ Other (specify)_____
□ Unknown

Prior Level of Functioning – Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury.

KEY

0 = No Impairment
1 = Mild Impairment
2 = Moderate Impairment
3 = Severe Impairment
4 = Complete Impairment
8 = Not Specified
9 = Not Applicable

_____ Self Care – bathing, dressing, eating, toileting
_____ Indoor Mobility (Walking) – room to room with/without devices
_____ Stairs (Walking) – internal/external – with/without devices
_____ Community Mobility (Walking) – shopping, etc.
_____ Indoor Mobility (WC) – room to room with wheeled device
_____ Community Mobility (WC) – shopping, etc.
_____ Functional Cognition – planning regular tasks, remembering meds

Mobility Devices and Aids Used Prior to Current Illness, Exacerbation, or Injury:

□ Cane or Crutch
□ Walker
□ Orthotic
□ Prosthetic Device
□ Manual WC full-time
□ Manual WC part-time
□ Power WC/Scooter full-time
□ Power WC/Scooter part-time
□ Environmental Control Device
□ Augmentative Communication Device
□ Mechanical Lift System
□ Standing Table
□ Other (specify) _____
□ None
□ Unknown

_____ Has the patient had two or more falls or any fall with injury in the past year?
0 = No 1 = Yes 9 = Unknown

III. Current Medical Information

A. Primary and Other Diagnoses, Co-morbidities and Complications

Primary Diagnosis at Assessment (be specific) _____

B. Other Diagnoses, Co-morbidities and Complications

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

9.	
10.	
11.	
12.	
13.	
14.	
15.	
	Is this list complete? 0 = No 1 = Yes

D. Major Treatments Which of the following treatments did the patient receive during the 2 day assessment period? For treatments such as blood transfusions, dialysis, or IV chemotherapy, is the patient currently receiving them as part of a treatment plan?

Admitted With (check all that apply)

1. □ None
2. □ Insulin Drip
3. □ Total Parenteral Nutrition
4. □ Central Line Management
5. □ Blood Transfusion(s)
6. □ Controlled Parenteral Analgesia – Peripheral
7. □ Controlled Parenteral Analgesia – Epidural
8. □ Left Ventricular Assistive Device (LVAD)
9. □ Continuous Cardiac Monitoring Specify Reason _____
10. □ Chest Tube(s)
11. □ Trach Tube with Suctioning. Specify most intensive frequency of suctioning _____
12. □ High O2 Concentration Delivery System with FiO2 > 40%
13. □ Non-invasive ventilation (CPAP)
14. □ Ventilator – Weaning
15. □ Ventilator – Non-weaning
16. □ Hemodialysis
17. □ Peritoneal Dialysis
18. □ Fistula or Other Drain Management
19. □ Negative Pressure Wound Therapy
20. □ Complex Wound Management with positioning, skin separation/traction that requires at least two persons or extensive and complex wound management by one person
21. □ Halo
22. □ Complex External Fixators (e.g. Ilizarov)
23. □ One-on-one 24 hours staff supervision. Specify reason _____
24. □ Specialty Surface or Bed (e.g. air fluidized, bariatric, low air loss, or rotation bed)
25. □ Multiple Types of IV Antibiotic Administration
26. □ IV Vasoactive Medications (e.g. pressors, dilators, medication for pulmonary edema)

27. □ IV Anti-Coagulants
28. □ IV Chemotherapy
29. □ Indwelling Bowel Catheter Management System
30. □ Other Major Treatments (e.g. isolation, hyperthermia blanket)
Specify _____

E. Medications Attach current Medication List

F. Allergies & Adverse Drug Reactions 0 = No 1 = Yes

	Allergies/Causes of Reaction		Patient Reaction
1.a		1.b	
2.a		2.b	
3.a		3.b	

IV. Medical Management Domain

A. Physiologic Factors

Record the most recent value for each of the following physiologic factors tested during the admission assessment period. Indicate the date (MM/DD/YYYY) that the value was collected. If the test was not provided during the admission assessment period, check "not tested". If it is not possible to measure the height and weight, check box if value is estimated (actual measurement is preferred.)

Anthropometric Measures

	Date	Values (xxx.x)	Check if not tested	Check if Estimated
1. Height		□ in □ cm		
2. Weight		□ lb □ kg		

Other Physiologic Measurements

	Date	Value – use format listed	Check if not tested
Temperature		xxx.x □ ◦F □ ◦ C	
Heart Rate (beats/min)		xxx	
Respiratory Rate (breaths/min)		xx	
Blood Pressure (mm/HG)		xxx/xxx	
O2 Saturation (Pulse Oximetry) %		xxx%	
Specify source of 02 supplementation			
Hemoglobin (gm/dL)		xx.x	
Hematocrit (%)		xx.x	
WBC (K/mm3)		xxx.x	
HbA1c(%)		xx.x	
Sodium (mEq/L)		xxx	
Potassium (mEq/L)		x.x	
BUN (mg/dL)		xxx	

Creatinine (mg/dL)		xx.x	
Albumin (gm/dL)		xx.x	
Prealbumin (mg/dL)		xx.x	
INR		x.x	
Left Ventricular Ejection Fraction (%) (this or prior setting acceptable)		xx	
Arterial Blood Gas (ABG's) Please specify source and amount of O2 supplementation			
pH		x.xx	
PaCO2 (mm/Hg)		xxx	
HCO3 (mEq/L)		xxx	
PaO2 (mm/Hg)		xxx	
SaO2 (%)		xx	
B.E. (base excess) (mEq/L)		xx	
Pulmonary Function Tests			
FVC (literes)		x.xx	
FEVI % or FEVI/FVC (%)		xx	
FEVI (liters)		x.xx	
PEF (liters per minute)		x.xx	
MVV (liters per minute)		xxx	
TLC (liters)		x.xx	
FRC (liters)		x.xx	
RV (liters)		x.xx	
ERV (liters)		x.xx	

B. Skin Integrity

_____ Is the patient at risk for developing pressure ulcers?
0 = No
1 = Yes, indicated by clinical judgment
2 = Yes, indicated high risk by formal assessment (Braden or Norton tools) or the patient has a stage 1 or greater ulcer, a scar over a bony prominence, or a non-removable dressing, device, or cast

_____ Does this patient have one or more unhealed pressure ulcer(s) at stage 2 or higher or unstageable?
0 = No
1 = Yes

If the patient has one or more stage 2-4 or unstageable pressure ulcers, indicate the number of unhealed pressure ulcers at each stage.		
Coding	Number present at Admission	Pressure Ulcer Description
Please specify the number of ulcers at each stage: 0 = 0 ulcers 1 = 1 ulcer 2 = 2 ulcers 3 = 3 ulcers	Stage 2: _____	Stage 2 – Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister (excludes those resulting from skin tears, tape stripping, or incontinence associated dermatitis.)
	Stage 3 _____	Stage 3 – Full thickness tissue loss. Subcutaneous fat maybe visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
	Stage 4	Stage 4 – Full thickness tissue loss with visible bone, tendon, or muscle.

4 = 4 ulcers 5 = 5 ulcers 6 = 6 ulcers 7 = 7 ulcers 8 = 8 or more ulcers 9 = Unknown	_____	Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
	Unstageable _____	Unstageable – Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, gray, green or brown) or eschar (tan, brown or black) in the wound bed. Include ulcers that are known or likely, but are not stageable due to non-removable dressing, device, cast or suspected deep tissue injury in evolution.

_____ Number of unhealed stage 2 ulcers known to be present for more than 1 month
If the patient has no unhealed stage 2 pressure ulcers, record the number present today that were first observed more than 1 month ago, according to the best available records.
If the patient has no unhealed stage 2 pressure ulcers, record "0". If the patient has 8 or more unhealed stage 2 pressure ulcers, record "8". If unknown, record "9".

Measurements of unhealed stage 3 or 4 pressure ulcers:

	If any unhealed pressure ulcer is stage 3 or 4 (or if eschar is present) record the most recent measurements for the largest ulcer or eschar:	_____If any unhealed stage 3 or 4 pressure ulcer(s) has undermining and/or tunneling (sinus track present) 0 = No 1 = Yes 8 = Unable to Assess
__ __ . __ cm	Longest length in any direction (enter 99.9 if the largest ulcer is unstageable and is not eschar)	
__ __ . __ cm	Width of same unhealed ulcer or eschar (enter 99.9 if the largest ulcer is unstageable and is not eschar)	
__ __ . __ cm	Depth of same unhealed ulcer or eschar (enter 99.9 if the largest ulcer is unstageable and is not eschar)	
Date Measured ___/___/_____ MM DD YYYY	Date of the measurement	

Number of Major Wounds
(excluding pressure ulcers)

_____ Delayed healing of surgical wound
_____ Trauma-related wound (e.g. burn)
_____ Diabetic food ulcer (s)
_____ Vascular ulcer (arterial or venous Including diabetic ulcers not on the foot)
_____ Other (e.g. incontinence associated Dermatitis, normal surgical wound healing
Specify _____

Turning Surfaces Not Intact
Indicate which of the following turning surfaces Have either a pressure ulcer or major wound:
(Check all that apply)
□ Skin for all turning surfaces is intact
□ Right hip not intact
□ Left hip not intact
□ Back/buttocks not intact
□ Other turning surface(s) not intact

C. Respiratory Status

Body Function & Structure:

____Does the patient have any deficits or require equipment related to respiratory status? 0 = No

1 = Yes If no, skip to the next section. If yes, please check below all that apply:
□ Ventilator – full time □ Ventilator – night only □ BIPAP □ CPAP
□ Tracheostomy □ Bronchitis □ Pneumonia □ COPD
□ Shortness of Breath □ Asthma □ Oxygen Use □ Inhaler Use
□ Other (specify)_____

Impairment:

Score (ICF)	
	Respiration Rate – the number of breaths taken per minute (e.g. tachypnea or bradypnea)
	Respiratory Rhythm – the periodicity and regularity of breathing

Use the ICF Rating Scale unless otherwise instructed:
0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

	Depth of Respiration – the volume of expansion of the lungs during breathing
	Respiratory Muscles – functions of the diaphragm, thoracic, and accessory muscles in breathing
	Clearing the lungs – ability to cough, sneeze or otherwise clear the airways of phlegm

Activity Limitations & Participation Restrictions

Score (ICF)	
	Monitoring health status – ability to monitor respiratory rate and know when to get help
	Self-Administering treatments – ability to administer basic respiratory treatments/technology (e.g. CPAP, O2, Inhalers, Aerosols)
	Management of Trach – Able to connect/disconnect PMV and perform cleaning/maintenance or to direct a caregiver to do so
	Management of Vent – Able to connect/disconnect vent and perform cleaning/maintenance or to direct a caregiver to do so
	Advanced Technology – Able to coordinate ventilator and other technology necessary for advanced IADLs such as controlling environment, propelling a power wheelchair, or accessing a computer.
	Independent with respiratory management in the individual's unique community, school and/or work environments.

D. Nutrition & Swallowing

____Does patient have any deficits with taking in nutrition and swallowing? 0 = No 1 = Yes
2 = Unable to rate If 0 or 2, skip to next section

Body Function & Structure

Score (ICF)	
	Sucking – drawing into the mouth by a suction force produced by movements of the cheeks, lips and tongue
	Biting – cutting into, piercing or tearing off food with the front teeth
	Chewing – crushing, grinding and masticating food with the back teeth (e.g. molars)
	Manipulation of food in the mouth – moving food around the mouth with the teeth and

	tongue
	Manage oral secretions (e.g. drooling, excessive oral dryness)
	Oral Swallowing – clearing food and drink from the oral cavity at an appropriate rate and speed

Use the ICF Rating Scale unless otherwise instructed:
0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

Impairments

____ Swallowing Use the following scale (FAM)
7 = Completely Independent - able to eat a regular diet of choice in a reasonable amount of time
6 = Modified Independent - able to eat a regular diet by mouth. May require excessive time for eating. May require assistive devices or multiple swallows to clear food.
5 = able to take all nourishment by mouth. May need modified diet. Supervision required for cueing, coaxing. May need assistance with food choices.
4 = able to take primary nourishment by mouth. May require diet restrictions. Minimal assistance required to monitor speed and amount of food intake. Subject performs 75% of the activity.
3 = able to take some nourishment by mouth. May require diet restrictions and modifications. May require moderate assistance to monitor speed and amount of food intake. Subject performs 50 - 74% of the activity.
2 = unable to receive adequate nourishment via oral feedings. Tube feedings provide primary nutrition. Oral feedings are limited and require maximal assistance. Subject performs 25 - 49% of the activity.
1 = unable to take anything by mouth. Nutrition is provided via tube feedings.

Activity Limitations & Participation Restrictions

Score (ICF)	
	Eating – carrying out the coordinated tasks and actions of eating food that been served, bringing it to the mouth and consuming it in culturally acceptable ways, cutting or breaking food into pieces, opening bottles and cans, and using eating utensils. If primary nutritional intake is via tube feeding, score 9
	Drinking – Taking hold of a drink, bringing it to the mouth, and consuming the drink in culturally acceptable ways, mixing, stirring and pouring liquids for drinking, opening bottles and cans, drinking through a straw or drinking running water such as from a tap or a spring; feeding from the breast or bottle. If primary nutritional intake is via tube feeding, score 9
	Managing Diet – Caring for oneself by being aware of the need and by selecting and consuming nutritious foods, following a specialized diet, or making appropriate food choices in a community setting.

E. Chronic Health Conditions & Management

____Does the patient have any chronic health conditions which require ongoing monitoring?
0 = No 1 = Yes 2 = Unable to rate If 0 or 2, skip to the next section

Body Function & Structure – Check all that apply:

□ Diabetes Mellitus □ Hyper/Hypotension □ COPD □ Hyperlipidemia
□ Cardiac □ GI related □ GU/Renal □ Arterio/atherosclerosis
□ Other (specify)_____

Use the ICF Rating Scale unless otherwise instructed:
0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

Activity Limitations & Participation Restrictions

Score (ICF)	
	Medical Monitoring – able to self-monitor key physiologic metrics (e.g. FBS, BP) or direct caregiver
	Health monitoring – able to recognize signs and symptoms (e.g. low blood sugar, cardiac) and know how to react, when to call for help, etc.
	Medication Management – knowledge of medications, dosages, storage, and can independently manage or direct caregiver
	Communication of Health – manages a personal health profile, keeping it up to date and available

F. Activity Tolerance

____Does the patient have any deficits in activity tolerance? 0 = No 1 = Yes 2 = Unable to rate
If 0 or 2, skip to the next section.

Body Function & Structure – Check all that apply in limiting activity tolerance
□ Hypertension □ Hypotension □ Hyperglycemia □ Hypoglycemia
□ Somnolence □ O2 Desaturation □ Pain □ Altered Sleep/Wake
□ Mental Status Change□ Other (specify) _____

Impairments

Score (ICF)	
	Sleep-Wake Cycle – able to stay awake for 4 hour time periods during normal daytime cycle
	Sitting Tolerance – able to sit for an hour at a time
	Mobility – able to walk or wheel a minimum of 150 feet without a rest break (If can do 150 feet but needs one rest break, score "1")
	Physical Activity – able to tolerate minimum 3 hours of activity throughout the day, with rest breaks
	Physical Activity – able to tolerate minimum 20 minutes of continuous physical activity without a rest break. (JB research) If tolerates 20 minutes but needs one rest break, score "1".
	Cognitive Endurance – able to tolerate minimum 15 minute continuous cognitive activity without a rest break (If can do 15 minutes but needs one rest break, score "1") (ICF)

Use the ICF Rating Scale unless otherwise instructed:
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1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

Activity Limitations & Participation Restrictions

Score (ICF)	
	Self care – Activity tolerance necessary to complete basic self-care.
	Home Management- Activity tolerance necessary to complete home management tasks (cooking, cleaning, shopping, finances, yard care)
	Community – Activity tolerance necessary to access one's community for shopping, social, or civic activities
	Work/School – Activity tolerance necessary to return to a full day at work or school
	Fitness – Ability and knowledge regarding appropriate participation in a regular exercise program at least 150 minutes per week.

G. Sleep

____Does the patient have deficits in sleep patterns? 0 = No 1 = Yes 2 = Unable to rate
If 0 or 2, skip to next section

Score (ICF)	
	Amount – time spent in the state of sleep in diurnal cycle or circadian rhythm
	Onset – transition between wakefulness and sleep
	Maintenance – ability to sustain the state of being asleep
	Quality – natural sleep leading to optimal physical and mental rest and relaxation

V. **Sensory Domain** (Vision, Hearing, Vestibular, Tactile, Gustatory, Pain)

Vision & Visual Perception

____ Does the patient have any deficits in vision or visual perception? 0 = No 1 = Yes 2 = Unable to rate If 0 or 2, skip to the next section. If yes, check all that apply:
□ Cranial nerve palsy □ Eye socket injury □ Eye ball injury □ Macular Degeneration
□ Retinitis Pigmentosa □ Cateracts □ Diabetic LV? □ Eye(s) missing
□ Double Vision □ Blurry Vision □ Visual Neglect □ Heminanopsia
□ Other (specify)_____

Impairments

Score (ICF)	
	Visual Acuity for distant vision – ability to sense size, form and contour for objects in the distance
	Visual Acuity for near vision – ability to sense size, form and contour for objects close by
	Visual field – seeing functions related to the entire area that can be seen with fixation of gaze
	Quality of Vision- light sensitivity – sensing a minimum amount of light and differences in intensity (e.g. night blindness, photophobia)

	Quality of Vision – colors – differentiating and matching colors

Use the ICF Rating Scale unless otherwise instructed:
0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

Impairments (cont)

	Quality of Vision – contrast – ability to separate figure from ground, involving the minimum amount of luminance required
	Quality of Vision – visual picture quality – seeing functions involving the quality of the picture (e.g. seeing stray lights, floaters, picture distortion)
	Eye structure – Internal Eye Muscles – functions of the muscles inside the eye, such as the iris, that adjust the shape and size of the pupil and lens (e.g. papillary reflex)
	Eye structure – Eyelid – functions of the eyelid, such as the protective reflex
	Eye structure – External Eye Muscles – functions of the muscles that are used to look in different directions, to follow an object as it moves across the visual field, to produce saccadic jumps to catch up with a moving target, to fix the eye. (e.g. nystagmus, cooperation of both eyes)

Activity Limitations & Participation Restrictions

Score (ICF)	
	Visual Perception of Body – ability to perceive whole body (e.g. left neglect)
	Visual Scanning – ability to safely maneuver through a home or community environment by perceiving and avoiding barriers, and then making adjustments to avoid them
	Visual Attention – ability to attend and sustain attention visually to environment and/or functional task necessary for the individual's life role (school, work, leisure activity)
	Use of Technology – Basic - ability to use low vision related assistive technology for ADLs (self care)
	Use of Technology – Advanced – ability to use low vision related assistive technology for IADLs (e.g. homemaking, financial management, etc)
	Use of Technology – Work/school – ability to use assistive technology for success in the individual's school or work environment and life role.

Hearing, Auditory Perception & Vestibular Function

____ Does the patient have any deficits in hearing, auditory perception or vestibular (balance)?
0 = No 1 = Yes 2 = Unable to rate If 0 or 2, skip to the next section.

Body Function & Structure – Check all that apply:
□ Inner Ear deficit □ Middle Ear deficit □ Cranial Nerve Palsy □ Tinnitus
□ Age related hearing loss □ Deaf □ BPPV □ Dizziness
□ Falling Sensation □ Nausea with vertigo
□ Other (specify) _____

Use the ICF Rating Scale unless otherwise instructed:
0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

Impairments

Score (ICF)	
	Auditory Perception – mental functions involved in discriminating sounds, tones, pitches and other acoustic stimuli
	Hearing Function – Sound detection – sensing the presence of sounds
	Hearing Function – Sound Localization – ability to determine the location of the source of sound
	Hearing Function – Speech Discrimination – determining spoken language and distinguishing it from other sounds
	Visuospatial Perception – mental function of distinguishing by sight the relative position of objects in the environment or in relation to oneself
	Vestibular function of position – sensing the position of the body in space
	Vestibular function of balance – sensing the balance of the body
	Vestibular function of determination of movement – sensing movement of the body, including its direction and speed
	Proprioceptive Function – sensing the relative position of body parts

Activity Limitations & Participation Restrictions

Score (ICF)	
	Ability to don and doff, change batteries and maintain hearing aids
	Auditory Compensation - Ability to safely maneuver through a home or community environment by perceiving and avoiding barriers through other means (e.g. visual) , and then making adjustments to avoid them
	Auditory Attention – ability to attend and sustain auditory attention to environment and/or functional task necessary for the individual's life role (school, work, leisure activity)
	Use of Technology – Basic - ability to use auditory related assistive technology for ADLs (e.g. vibration alarms to wake up) and IADLs (e.g. light or vibration device for telephone, door bell, etc)
	Use of Technology – Work/school – ability to use assistive technology for success in the individual's school or work environment and life role.

Other Sensory Systems – Tactile, Temperature, Olfactory and Gustatory Do we need this?

____ Does the patient have other sensory system deficits, such as with tactile (touch), temperature, olfactory (smell) and/or gustatory (taste)? 0 = No 1 = Yes 2 = Unable to rate If 0 or 2, skip to next section. If yes, check all that apply:
□ Peripheral Neuropathy □ Central Neuropathy □ Sensory Defensiveness?

□ Other (specify)_____

Use the ICF Rating Scale unless otherwise instructed:
0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

Impairments

Score (ICF)	
	Touch – sensing surfaces and their texture or quality (e.g. numbness, tingling, paraesthesia, hyperaesthesia)
	Taste – sensing qualities of bitterness, sweetness, sourness, and saltiness
	Smell – sensing odors and smells
	Other sensory perception – sensing of temperature, vibration, pressure and noxious stimuli.

Pain

____Pain Interview Attempted? 0 = No 1 = Yes If No, skip to G6 Pain Observation

____Pain Presence Ask patient: "*Have you had pain or hurting at any time during the last 2 days?*" 0 = No (skip to next section) 1 = Yes 8 = Unable to answer/no response (skip to G6)

____Pain Severity Ask patient: *Please rate your worst pain during the last 2 days on a zero to 10 scale, with zero being no pain and 10 as the worst pain you can imagine."* Enter 88 if patient does not answer or is unable to respond and skip to G6 Pain Observation.

____Pain Effect on Sleep Ask Patient: *"During the past 2 days, has pain made it hard for you to sleep?"* 0 = No 1 = Yes 8 = Unable to answer/no response

____Pain Effect on Activities Ask Patient: *"During the past 2 days, have you limited your activities because of pain?"* 0 = No 1 = Yes 8 = Unable to answer/no response

Pain Observational Assessment. If patient could not be interviewed for pain assessment, check all indicators of pain or possible pain.
□ Non-verbal Sounds (e.g. crying, whining, gasping, moaning, or groaning)
□ Vocal Complaints of pain (e.g. "that hurts, ouch, stop"
□ Facial Expressions (e.g. grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
□ Protective Body Movements/Postures (e.g. bracing, guarding, rubbing or massaging a body part or area, clutching or holding a body part during movement)
□ None of these signs were observed or documented

VI Bowel & Bladder Domain

____Does patient have any deficits related to bowel or bladder function? 0 = No 1 = Yes 2 = Unable to rate
If 0 or 2, skip to next section

Use the ICF Rating Scale unless otherwise instructed:

0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**

1 = Mild Impairment (5-24%)

2 = Moderate Impairment (25-49%) **8 = Not specified**

3 = Severe Impairment (50-95%) **9 = Not applicable**

Body Function & Structure: (ICF Score) Do we need these, or are they listed as co-morbidities?

Bladder	Bowel	Body Function
		Filtration of urine by the kidneys (e.g. renal insufficiency, anuria, oliguria, hydronephrosis) How measure?
		Discharge of urine from the bladder (continence and frequency, control)
		Sensations associated with urinary functions (feeling of incomplete voiding, bladder fullness) How measure?
		Transport of food through stomach and intestines (peristalsis and related functions to mechanically move food through stomach and intestines) How measure?
		Elimination of faeces How measure?
		Faecal continence (voluntary control)
		Sensations associated with bowel functions (nausea, bloated, abdominal cramp) How measure, and how discern between impact of meds vs assoc with bowel?

Impairments

Bladder	Bowel		Rating Scale
		Does the patient require an indwelling device? Would it be better to put "use"?	0 = No 1 = Yes
		Does the patient require medications for regularity? Management?	0 = No 1 = Yes
		Does the patient require intermittent catheterization?	0 = No 1 – Yes
		Frequency of Incontinence	0 = Continent (no documented incontinence) 1 = Stress Incontinence only (bladder only) 2 = Incontinent less than daily (only once during 2 day assessment) 3 = Incontinent daily (at least once per day) 4 = Always incontinent 5 = No urine/bowel output (e.g. renal failure) 9 = Not applicable (e.g. indwelling catheter)
		If the patient is incontinent or has an indwelling device, was the patient incontinent (excluding stress incontinence) immediately prior to the current illness, exacerbation or injury?	0 = No 1 = Yes 9 = Unknown

Use the ICF Rating Scale unless otherwise instructed:

0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**

1 = Mild Impairment (5-24%)

2 = Moderate Impairment (25-49%) **8 = Not specified**

3 = Severe Impairment (50-95%) **9 = Not applicable**

Activity Limitations (ICF Scale)

Bladder	Bowel	
		External Device (e.g urinal, bedpan, incontinence pads/undergarments): Ability to set up, empty, clean up and maintain device.
		Intermittent Catheterization: Ability to set up, insert, remove, clean up, follow catheterization schedule, and monitor fluid intake.
		Colostomy/Ostomy: The ability to empty, change and properly care for colostomy or ostomy site.
		Neurogenic Bowel Care Program: The ability to perform all steps of a neurogenic bowel care routine as recommended.
		Use of Adaptive Equipment (e.g. digital stimulation device, suppository inserter, pant holder, etc)
		Use of Adapted Strategies (e.g. initiate and follow timed voiding schedule, fluid management, diet restrictions and medications)
Bladder	Bowel	Toileting
		Indicating need for toileting
		Transferring on/off the toilet or commode
		Manipulating clothing before and after toileting
		Cleaning oneself after toileting

Participation Restrictions (ICF Scale)

Score (ICF)	Participation Items
	External Devices: Ability to perform or to direct caregivers regarding use of external devices
	Intermittent Catheterization: Ability to perform or to direct caregivers regarding process for intermittent catheterization
	Colostomy/Ostomy: Ability to perform or to direct caregivers regarding care of colostomy/ostomy.
	Neurogenic Bowel Care: Ability to perform or to direct caregivers regarding process for bowel program
	Adaptive Equipment: Ability to perform or to direct caregivers regarding use of adaptive equipment (e.g digital stimulation device, suppository inserter, pant holder, etc) for bladder and bowel management
	Adaptive Strategies: Ability to perform or to direct caregivers regarding use of adaptive strategies (e.g. initiate and follow timed voiding schedule, fluid management, diet restrictions and medications) for bladder and bowel management
	Toilet transfers: Ability to perform or to direct a caregiver regarding toilet transfer techniques
	Ability to perform or direct caregivers regarding toileting in a community, work or school setting.

Use the ICF Rating Scale unless otherwise instructed:

0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

VII Cognition Domain

A. Consciousness

____ Is the patient conscious? 0 = No 1 = Yes If no, skip to the next section

Score (ICF)	
	State of Consciousness – Clouding of consciousness, stupor or coma
	Continuity of Consciousness – sustained wakefulness, alertness, awareness, and when disrupted may produce fugue, trance or other similar states
	Quality of Consciousness – character of wakeful, alert and aware sentience, such as drug-induced altered states or delirium

B. Orientation to Person, Place and Time

____Is the person oriented to person, place and time? 0 = No 1 = Yes 2 = Unable to rate
If 0 or 2, skip to next section

Score (ICF)	
	Time – awareness of day, date, month and year
	Place – awareness of one's location (immediate surroundings, town, country)
	Person – awareness of own's own identity
	Others – awareness of identity of individuals in one's immediate environment

C. Attention

____Does the patient have deficits related to attention? 0 = No 1 = Yes 2 = Unable to rate
If 0 or 2, skip to next section

Score (ICF)	
	Sustaining attention – concentration for the period of time required
	Shifting attention – ability to refocus concentration from one stimulus to another
	Dividing attention – ability to focus on two or more stimuli at the same time
	Sharing attention – ability to focus on the same stimulus by two or more people, such as a child and a caregiver both focusing on a toy.

D. Memory

____Does the patient have deficits in short or long term memory? 0 = No 1 = Yes 2 = Unable to rate If 0 or 2, skip to next section

Score (ICF)	

	Short Term – a temporary, disruptable memory store of around 30 seconds duration
	Long term – ability to convert short term to long term storage of both autobiographical memory (past events) and semantic memory (language and facts)
	Retrieval – ability to recall information stored in long-term memory and bring into awareness

Use the ICF Rating Scale unless otherwise instructed:
0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

E. Thought

____Does the patient have deficits in the area of thinking? 0 = No 1 = Yes 2 = Unable to rate
If 0 or 2, skip to next section.

Score (ICF)	
	Pace – speed of thinking process
	Form – organization of the thinking process as to its logic and coherence (e.g. perseveration, tangentiality and circumstantiality)
	Content – ideas that are present in the thinking process (e.g. delusions, overvalued ideas and somatization)

F. Motor Sequencing

____Does the patient have any deficits in the area of motor sequencing? 0 = No 1 = Yes 2 = Unable to rate
If 0 or 2, skip to the next section

Score (ICF)	
	Sequencing and coordinating complex, purposeful movement (e.g. oculomotor and speech apraxia)

G. Higher Level Cognition

____Does the patient have deficits in areas of higher level cognition, for example insight, judgment, time management or problem solving? 0 = No 1 = Yes 2 = Unable to rate If 0 or 2, skip to next section.

Score (ICF)	
	Abstraction – creating general ideas, qualities or characteristics out of concrete realities, objects or instances
	Organization & planning – coordinating parts into a whole, systematizing, developing a method of proceeding or acting.
	Time management – ordering events in chronological sequence, allocating amounts of time to events/activities
	Cognitive flexibility – changing strategies or shifting mental sets especially as part of problem solving
	Insight – awareness and understanding of oneself and one's behavior
	Judgment – discriminating between and evaluating different options, such as when forming an opinion
	Problem Solving – identifying, analyzing and integrating incongruent or conflicting information

	into a solution

Use the ICF Rating Scale unless otherwise instructed:
0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

H. Psychomotor

____Does the patient have deficits in psychomotor functions such as response time and coordination?
0 = No 1 = Yes 2 = Unable to rate If 0 or 2, skip to next section

Score (ICF)	
	Control – speed of behavior or response time that involves both motor and psychological components
	Quality – non-verbal behavior e.g. hand-eye coordination

Activity Limitations & Participation Restrictions

Score (ICF)	
	Acquiring Skills – ability to learn new skills, both simple (e.g. using a utensil to eat) and complex (e.g. learning to play a sport). To score a "0", the subject must be able to learn an integrated set of actions so as to follow rules and sequence and coordinate one's movements, such as learning a new game or using a building tool.
	Problem Solving – ability to solve simple (e.g. single issue) or complex (multiple issues) problems. To score a "0", the subject must be able to find solutions to a complex problem involving multiple and interrelated issues by identifying and analyzing the issue, developing solutions, evaluating the potential effects, and executing a chosen solution.
	Calculating – performing computations by applying mathematical principles to solve problems that are described in words and producing or displaying the results, such as computing the sum of three numbers.
	Undertaking a Single Task – carrying out simple or complex and coordinated actions related to the mental and physical components of a single task, such as initiating a task, organizing time, space, and materials for a task, pacing task performance, and carrying out, completing and sustaining the task.
	Undertaking Multiple Tasks – carrying out simple or complex and coordinated actions as components of multiple, integrated and complex tasks in a sequence or simultaneously.
	Daily Routine Management – carrying out simple or complex and coordinated actions in order to plan, manage and complete the requirements of day to day procedures or duties, such as budgeting time and making plans for separate activities throughout the day.
	Life Role – cognitive abilities necessary for success in the individual's community, school and/or work environments and life role (homemaker, parent, worker, student)

Use the ICF Rating Scale unless otherwise instructed:

0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

VIII Communication Domain

____Does the patient have any deficits in communication? 0 = No 1 = Yes 2 = Unable to rate
If 0 or 2, skip to next section. If yes, check all that apply:
□ Ventilator □ Tracheostomy Tube □ PMV □ Laryngectomy
□ Missing Teeth □ Dentures □ Facial Paralysis □
□ Other oral structure malformations (specify)_____

Impairments

Score	
	Production of voice – production of sound made through coordination of the larynx and surrounding muscles with the respiratory system (e.g. loudness, phonation)
	Quality of voice – production of characteristics of voice including pitch, resonance and other features (e.g. pitch, nasality, hoarseness)
	Articulation – production of speech sounds (e.g. enunciation, articulation of phonemes, spastic, ataxic, flaccid Dysarthria, anarthria)
	Fluency – production of smooth, uninterrupted flow of speech (e.g. stuttering, stammering, cluttering, dysfluency, repetition of sounds, words or parts of words and irregular breaks in speech)
	Rhythm of speech – modulated, tempo, and stress patterns in speech (e.g. stereotypic or repetitive speech cadence)
	Receptive Language
	Expressive Language

Activity Limitations

Score	
	Receiving Spoken Messages – comprehending literal and implied meanings of messages
	Receiving Nonverbal Messages – comprehending the meaning conveyed by facial expressions, hand movements, body postures, other forms of body language, sign/symbols (e.g. traffic signs), and drawings or photographs (e.g. graphs, charts)
	Receiving Written Messages – comprehending the literal and implied meanings of messages that are conveyed through written language e.g. following political events in the daily newspaper or understanding the intent of religious scripture.
	Speaking – producing words, phrases and longer passages in spoken messages with literal and implied meaning, such as expressing a fact or telling a story in oral language.
	Producing Nonverbal Messages – conveying meaning by movements of the body, such as facial gestures (e.g. smiling, frowning, wincing), arm and hand movements and postures (e.g. embracing to indicate affection), use of signs or symbols, and/or use of drawings or photographs.

Use the ICF Rating Scale unless otherwise instructed:

0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**

1 = Mild Impairment (5-24%)

2 = Moderate Impairment (25-49%) **8 = Not specified**

3 = Severe Impairment (50-95%) **9 = Not applicable**

Activity Limitations (cont)

Score (ICF)	
	Producing Written Messages – producing the literal and implied meanings of messages that are conveyed through written language, such as writing a letter to a friend.
	Conversation – starting, sustaining and ending an interchange of thoughts and ideas, carried out by means of spoken, written, sign or other forms of language with one or more persons in a formal or casual setting.
	Communication Devices – Writing – using machines for writing such as typewriters, computers, or Braille writers as a means of communication
	Communication Devices – Speaking – using an alternative/augmentative communication device for expressing wants and needs.

Participation Restrictions

Score (ICF)	
	Auditory Comprehension necessary for success in the individual's community, work and/or school environment with or without assistive device. To score a "0" the subject must be independent without an assistive device.
	Written comprehension necessary for success in the individual's community, work and/or school environment with or without assistive device. To score a "0" the subject must be independent without an assistive device.
	Expressive oral communication necessary for success in the individual's community, work and/or school environment with or without assistive device. To score a "0" the subject must be independent without an assistive device.
	Expressive written communication necessary for success in the individual's community, work and/or school environment with or without assistive device. To score a "0" the subject must be independent without an assistive device.
	Electronic communication (email, internet, other software programs) necessary for success in the individual's unique work and/or school environment with or without assistive device. To score a "0" the subject must be independent without an assistive device.

Use the ICF Rating Scale unless otherwise instructed:
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1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

IX Self-Care & Home Management Domain

____Does the patient have any difficulties with basic self-care or advanced skills such as homemaking, financial management, yard care, etc.? 0 = No 1 = Yes 2 = Unable to rate If 0 or 2, skip to next section. If yes, check all that apply (body structure and function):
□ UE Amputation □ UE Paralysis/Paresis □ Hemiparalysis/paresis □ Spasticity
□ Neck/Back Brace □ Sternal Precautions □ UE Wt Bearing Restriction □ Burns/Wounds
□ Other (specify)_____

Impairments

Score (ICF)	
	Upper Extremity Range of Motion How score?
	Upper Extremity – Gross Motor Strength How score?
	Upper Extremity – Fine Motor Strength, including grasp and pinch How score?
	Trunk Control How score?
	Sitting Balance – ability to maintain sitting on the side of the bed without support
	Fine Motor Coordination – ability to use fingers in a coordinated manner to complete fine motor tasks such as buttoning a blouse, writing or manipulating eating utensils
	Sensory deficits as barriers to self-care
	Cognitive deficits as barriers to self-care

Activity Limitations & Participation Restrictions

Score (ICF)	
	Washing oneself – washing and drying one's whole body, or body parts, using water and appropriate cleaning and drying materials or methods, such as bathing, showering, washing hands and feet, face and hair, and drying with a towel.
	Caring for body parts – looking after those parts of the body, such as skin, face, teeth, scalp, nails and genitals, that require more than washing and drying (e.g. moisturizing hands, applying cosmetics, dental hygiene, shaving, trimming toe and finger nails)
	Upper Body Dressing
	Lower Body Dressing
	Tub/Shower Transfers – ability to safely get in/out of tub or shower
	Shopping – Obtaining, in exchange for money, goods and services required for daily living (includes instructing and supervising a caregiver to do the shopping), such as selecting food, drink, cleaning materials, household items or clothing in a shop or market, comparing quality and price of the items required, negotiating and paying for selected goods or services and transporting goods.
	Preparing Simple Meals – Organizing, cooking and serving meals with a small number of ingredients that require easy methods of preparation and serving, such as a snack or small meal, and transforming food ingredients by cutting and stirring, boiling and heating food such as rice or potatoes.

Use the ICF Rating Scale unless otherwise instructed:

0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

Activity Limitations & Participation Restrictions (cont)

Score (ICF)	
	Preparing Complex Meals – Planning, organizing, cooking and serving meals with a large number of ingredients that require complex methods of preparation and serving, such as planning a meal with several dishes, and transforming food ingredients by combined actions of peeling, slicing, mixing, kneading, stirring, presenting and serving food in a manner appropriate to the occasion and culture.
	Cleaning Cooking Area & Utensils – Cleaning up after cooking, such as by washing dishes, pans, pots and cooking utensils, and cleaning tables and floors around the cooking area.
	Cleaning Living Area – Such as tidying and dusting, sweeping, mopping floors, cleaning bathrooms and toilets, and other household furnishings.
	Using Household Appliances – Such as washing machines, driers, irons, vacuum cleaner and dishwashers.
	Maintaining Dwelling & Furnishings – Repairing and taking care of dwelling, its exterior, interior and contents, such as by painting, repairing fixtures and furniture, and using required tools for repair work.
	Maintaining Vehicles – Repairing and taking care of motorized vehicles, such as automobiles
	Maintaining DME, including wheelchairs, or directing a caregiver to do so
	Taking care of plants, indoor and outdoor – Taking care of plants such as by planting, watering, fertilizing plants; gardening and growing foods for personal use.
	Taking care of animals – Taking care of domestic animals and pets, such as by feeding, cleaning, grooming and exercising pets, watching over the health of animals or pets.
	Financial Management – Managing daily finances including planning and following a budget, making transactions at a bank or financial institution, using and balancing a check book, and filing tax returns.
	Assisting Others – Helping household members, such as spouse or children, with their learning, communication, self-care, movement, within the house or outside, and being concerned about the well-being of household members and others. (e.g. parenting, caring for an aging parent or ailing spouse).
	Self-care skills necessary for success in the individual's community, school and/or work environment, such as managing lunch in a school cafeteria, toileting in a public restroom, or unique dressing related to specific job or role (e.g. donning/doffing sports uniforms/equipment, specialized clothing or footwear for a construction job, or selecting/wearing appropriate clothing for a formal business meeting.)

Types of Devices used (check all that apply)

□ Reacher □ Built up Tools □ Low Tech Dressing Aids □ Low Tech Bathing Aids
□ Tub Bench □ Toilet Riser □ Low Tech Toileting Aids □ Low Tech Grooming Aids
□ Grab Bars □ Memory Device □ Low Tech Cooking Aids □ Low Tech Homemaking Aids

□ Other (specify) _____

Use the ICF Rating Scale unless otherwise instructed:
0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

X. Mobility, Locomotion & Transportation

____Does the patient have deficits in the area of mobility or locomotion? 0 = No 1 = Yes 2 = Unable to rate If 0 or 2, skip to the next section

Body Function & Structure – Check all that apply
□ LE Amputation □ LE Paralysis/Paresis □ Hemiparalysis/paresis □ Spasticity
□ Back Brace □ Hip/Knee Precautions □ LE Wt Bearing Restriction _____
□ Other (specify)_____

Impairments

Score (ICF)	
	Lower Extremity Range of Motion How score?
	Lower Extremity – Gross Motor Strength How score?
	Trunk Strength & Control How score?
	Standing Balance – ability to maintain standing without support
	Lower Extremity Motor Control & Coordination – ability to move legs in a coordinated manner in accordance with instructions or a plan (e.g. step sideways, step forward or backward, move legs in a cycling motion)
	Sensory deficits as barriers to locomotion
	Cognitive deficits as barriers to locomotion

Activity Limitations & Participation Restrictions

Score (ICF)	
	Rolling – moving from one lying position to another on the same level
	Lying Down – getting into and out of a lying down position or changing body position from horizontal to sitting, or sitting to lying down.
	Sit to/from Stand – getting into and out of a seated position and changing body position from sitting to standing or standing to sitting.
	Bending – Tilting the back downwards or to the side, at the torso, such as bowing or reaching down for an object on the floor.
	Weight Shifting – Adjusting or moving the weight of the body from one position to another while seated or standing, such as moving form one foot to another while standing, or performing seated weight shifts for pressure relief.
	Seated Transfers – moving from a sitting position on one seat to another seat on the same or a different level, such as moving from chair to bed, bed to chair.
	Floor to Sit/stand – moving from the floor to a chair or to standing, including giving caregiver directions regarding how to help. To score a "0" the patient must be independent without

	assistive devices or caregiver assistance.

Use the ICF Rating Scale unless otherwise instructed:
0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

Activity Limitations & Participation Restrictions (Continued)

Score (ICF)	
	Car Transfers – ability to approach a vehicle, unlock doors, move from standing or seating into the car seat, apply seat belt, and reverse. If a person uses a wheelchair or other mobility device (e.g. walker), this also includes disassembling and reassembling that device, storing it in the vehicle and retrieving it.
	Household Ambulation – walking ≤ 150 feet such as walking around rooms or hallways, within a building, or for short distances outside
	Community Ambulation – walking ≥150 feet such as walking blocks, doing shopping, or in the school or work place
	Walking on different surfaces – ability to walk on sloping or uneven surfaces such as on grass, gravel, ice or snow.
	Walking around obstacles – ability to walk in ways required to avoid moving and immobile objects, people, animals, and vehicles, such as walking around a market place, around or through traffic, school, work or other crowed areas.
	Crawling – moving the whole body in a prone position from one place to another on hands, or hands and arms, and knees.
	Climbing – Moving the whole body upwards or downwards, over surfaces or objects, such as climbing steps, ladders or stairs, curbs or other objects.
	Running – Moving with quick steps so that both feet may be simultaneously off the ground.
	Jumping – moving up off the ground by bending and extending the legs, such as jumping on one foot, hopping, skipping, and jumping or diving into water.
	Household Wheelchair Propulsion – propelling a manual or power wheelchair ≤150 feet such as traveling around rooms or hallways within a building, or for short distances outside.
	Community Wheelchair Propulsion – propelling a manual or power wheelchair ≥150 feet such as propelling blocks, doing shopping, or in the school or workplace.
	Wheelchair Propulsion over Different Surfaces – ability to propel a manual or power wheelchair on sloping or uneven surfaces such as on grass, gravel, ice or snow.
	Wheelchair Propulsion Around Obstacles – ability to propel a manual or power wheelchair in ways required to avoid moving and immobile objects, people, animals and vehicles, such as maneuvering around a market place, around or through traffic, school, work or other crowded areas.
	Community Access (FAM) – ability to manage transportation, including planning a route, time management, paying fares and anticipating access barriers (except car transfers). To score a "0" the patient is able to independently use public transportation (bus, van or taxi) or is able to drive a car with no safety considerations.

Use the ICF Rating Scale unless otherwise instructed:
0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

Types of Devices used (check all that apply):
□ Manual Wheelchair □ Power Wheelchair □ Scooter □ Walker/Wheeled Walker
□ Cane/Crutch □ Orthotics □ Prosthetics □ Mechanical Lift
□ Other (specify)_____

XI. Social-Emotional & Behavioral Domains

____Does the patient have any deficits in social-emotional areas, such as mood, regulation of emotion, stress management, socially-appropriate behaviors, adjustment, etc.? 0 = No 1 = Yes 2 = Unable to rate If 0 or 2, skip to next section

Body Structure & Function – Check all that apply
Not sure what to put here? Depression, Anxiety Disorder, H/O Substance Abuse???? Or skip because it would be listed as co-morbidity?

Impairments

Score (ICF)	
	Appropriateness of Emotion – Mental functions that produce congruence of feeling or affect with the situation, such as happiness at receiving good news.
	Regulation of Emotion – Mental functions that control the experience and display of affect. (e.g. lability)
	Range of Emotion – Mental functions that produce the spectrum of experience of arousal of affect or feelings, such as love, hate, anxiousness, sorrow, joy, fear and anger.
	Experience of Self – Mental functions of being aware of one's own identity and one's position in the reality of the environment around oneself.

____Supervision (Adapted from the Supervision Rating Scale)
0 = Independent (1-2)- Safe alone without supervision in an familiar or unfamiliar environment, 24 hours a day, 7 days per week, including overnight
1 = Overnight Supervision (3)– Safe alone without supervision in an familiar or unfamiliar environment but one or more persons are always present overnight.
2 = Part-time Supervision (4-7)– Safe alone for periods of time during waking hours but one or more supervising persons are always present overnight. Supervising persons are all absent for enough time to work full-time outside the home.
3 = Full-Time Indirect Supervision (8-9) – Requires full-time indirect supervision. At least one supervising person is always present, checking on the patient not more than once every 30 minutes. May also require additional overnight safety (e.g. deadbolt on outside door)
4 = Full-Time Direct Supervision (10-11) – Requires full-time direct supervision. At least one person supervising is always present and checks on the patient more than once every 30 minutes.

5 = Complete Supervision/Restraint (12-13) – Requires constant one-on-one supervision and/or physical restraints.
8 = Not Specified
9 = Not Applicable

Use the ICF Rating Scale unless otherwise instructed:
0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

Activity Limitations & Participation Restrictions

Score (ICF)	
	Basic Interpersonal Interactions – Interacting with people in a contextually and socially appropriate manner, such as by showing consideration and esteem when appropriate, or responding to the feelings of others (e.g. respect, tolerance, responding to differences of opinion or disagreement, giving and responding to social cues)
	Relationships – beginning, maintaining and ending relationship interactions with others in a contextually and socially appropriate manner
	Regulating Behaviors within Interactions – Regulating emotions and impulses, verbal and/or physical aggression in interactions with others, in a contextually and socially appropriate manner.
	Parent-Child Relationships – Being a parent, providing physical, intellectual and emotional nurture to one's natural or adoptive child.
	Child-Parent Relationships – Creating and maintaining relationships with one's parent, such as a young child obeying his/her parents or an adult child taking care of his/her elderly parents.
	Sibling Relationships – Creating and maintaining a brotherly or sisterly relationship with a person who shares one or both parents by birth, adoption or marriage.
	Intimate Relationships – Creating and maintaining close or romantic relationships between individuals, such as husband and wife, lovers, or sexual partners.
	Handling Stress and other Psychological Demands – Carrying out simple or complex and coordinated actions to manage and control the psychological demands required to carry out tasks demanding significant responsibilities and involving stress, distraction, or crisis, such as driving a vehicle during heavy traffic or taking care of many children.
	Employability (FAM) – Involvement in one or more of the following areas; in the workforce, as a student, or as a homemaker. To score a "0" the subject can compete in the open market for a wide range of jobs, plan, execute and assume responsibility for homemaking, or understand and carry out school assignments and maintain a passing average in an integrated school setting.
	Community Life – Engaging in all aspects of community social life, such as engaging in charitable organizations, service clubs or professional or social organizations.
	Recreation & Leisure – Engaging in any form of play, recreational, or leisure activity, such as informal or organized play and sports, relaxation, amusement.
	Religion & Spirituality – Engaging in religious or spiritual activities, organizations and practices for self-fulfillment, finding meaning, establishing connection with a divine power.

Use the ICF Rating Scale unless otherwise instructed:

0 = No Impairment (0-4%) **4 = Complete Impairment (96-100%)**
1 = Mild Impairment (5-24%)
2 = Moderate Impairment (25-49%) **8 = Not specified**
3 = Severe Impairment (50-95%) **9 = Not applicable**

XII. ENVIRONMENTAL & PERSONAL BARRIERS & FACILITATORS

Environmental and Personal factors can be barriers or can facilitate success. Using the ICF scale below, please rate the following environmental and personal factors, using a (+) sign if it has a positive impact, and a (-) sign if it has a negative impact.

0 = None (0-4%) 4 = Complete (96-100%)
1 = Mild (5-24%)
2 = Moderate (25-49%) 8 = Not specified
3 = Severe or Substantial (50-95%) 9 = Not Applicable

Score (above)	
	Home Physical Accessibility – Ability to physically access essential areas of the home including ingress/egress, bathroom, bedrooms, and kitchen/eating areas
	Communication Accessibility – Ability to access communication to external parties such as alerting authorities in case of fire, medical or other emergencies, etc
	Safety of Environment – Ability to maintain physical safety in one's home and immediate neighborhood, avoiding dangers such as from crime, weather, or other life endangering situations.
	Work or School Accessibility – Ability to access work or school environments and to fully participate in as integrated setting as possible (e.g. physical accessibility, reasonable accommodations for hearing, sight, or memory deficits, etc.)
	Housing Services, systems or policies (e.g. housing discrimination, availability of public or low income accessible housing, etc)
	Transportation Services, systems or policies (e.g. availability of accessible public transportation)
	Financial Situation – income to support basic daily living needs for food, shelter, clothing, etc.
	General social support services – availability of services of support in area such as shopping, housework, transport, and self-care in the home environment
	Health Services & systems – availability of healthcare services for preventing and treating health problems, providing medical rehabilitation, and promoting a healthy lifestyle
	Attitudes of immediate family members – general or specific opinions and beliefs of immediate family members about the person or about other matters (e.g. social, political,

	economic issues) that influence individual behavior and actions.
	Attitudes of people in positions of authority (e.g. teachers, employers) - general or specific opinions and beliefs of immediate family members about the person or about other matters (e.g. social, political, economic issues) that influence individual behavior and actions.

APPENDIX B
COMMENT LETTER ON SNF READMISSION PROPOSAL

Marsha Lommel, MA, MBA, FACHE
President and Chief Executive Officer
Madonna Rehabilitation Hospital
AMRPA Chair

July 25, 2013

Marilyn Tavenner
Administrator, Center for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Skilled Nursing Facility Readmission Measure Call for Public Comment

Dear Administrator Tavenner:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to submit comments regarding the development of a readmissions measure for skilled nursing facilities (SNFs). AMRPA is a national trade association representing over 500 freestanding rehabilitation hospitals, rehabilitation units of general hospitals, and outpatient rehabilitation service providers. Most, if not all, of our members are Medicare participating providers. Inpatient rehabilitation hospitals and units (IRH/Us) serve approximately 400,000 Medicare beneficiaries per year. Medicare Part A payments represent, on average, over 60 percent of IRH/Us revenues. AMRPA members work with patients to maximize health, functional skills, independence, and participation in society so they may return to home, work, and/or an active retirement.

To demonstrate AMRPA's commitment to quality improvement and development of proper quality measures, we created a Quality Committee in 2009, which has since worked in pursuit of these goals in the rehabilitation industry. The purpose of the committee is to explore the current status of definitions, development and use of quality measures and indicators, define principles pertaining to quality care in IRH/Us, adopt a framework for analyzing measures, and define such measures. The committee also analyzed the strategic considerations for promoting such measures in various forums, as well as the role of other types of entities such as Patient Safety Organizations (PSOs), and data networks, to name a few.

The mission of the committee is to identify structures and processes that lead to achievement of high quality outcomes and demonstrate achievement of those high quality outcomes. Our vision is that outcomes are measured accurately and consistently without excessive burden to the provider or patient. Outcomes must be relevant, meaningful, and understandable for the patient and the provider. Selected outcomes would ideally show that care is delivered in the absence of preventable negative occurrences with meaningful patient progress and in a cost effective, efficient manner.

Development of Readmissions Measures is Critically Important and Should be Done Carefully

One measure area on which the AMRPA Quality Committee has spent considerable time is readmissions. At this time, such a measure has been proposed in the fiscal year (FY) 2014 Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) as part of the IRF Quality Reporting Program (QRP). As we stated in our comment letter and interactions with CMS staff responsible for the IRF QRP, a key general concern is that any readmission measure(s) continue to preserve, if not enhance, access to needed medical rehabilitation services and does not unintentionally contain a disincentive to admitting complex patients in need of such services.
In this instance with respect to the proposed SNF readmission measure, in the measure justification document in support of the development of this measure, RTI states that the measure has been harmonized to the greatest extent possible with CMS' 30-day All-Cause Hospital-Wide Unplanned Readmission Measure (HWR), developed by Yale University. AMRPA analyzed the proposed measure in great detail and would like to offer the following general considerations and suggestions for the development of a readmissions measure for SNF.

I. Current Literature and Effort

We are aware that there is a large body of literature looking at the issue of readmissions to acute care hospitals from various settings, including home. The Post-Acute Care Payment Reform Demonstration (PAC-PRD) includes references to most of the current articles of interest. In addition, the AHRQ Healthcare Cost and Utilization Project (HCUP) has published two briefs – one on 30 Day Readmissions following Hospitalizations for All Cause Readmission by Payer and Age and one on Chronic vs. Acute Conditions for 2008. The report entitled "*Hospital-Wide All Cause Unplanned Readmission Measure*," as developed by the Yale-New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (Yale) was reviewed by our committee and also forms the basis for some of our comments.

In addition, the National Quality Forum (NQF) created a consensus standards endorsement project which recently issued a report titled "*Patient Outcomes: All Cause Readmissions Expedited Reviews 2011: A Consensus Report,*" which discussed three potential readmissions measures and sought public comment thereon. AMRPA submitted comments on the NQF report.

II. Factors to be Addressed

As we address both measurement and prevention of readmissions, we believe there are several factors to be considered.

A. Data to be Used for the Analysis

The number of readmissions, however defined, should be based on data from multiple years in order to provide a sufficiently robust database. We are concerned that analyzing only one year of data, for

example, may risk inclusion of an atypical year. For example in the IRH/U space, there have been numerous regulatory changes. Starting in July 2004 the 75% Rule was rewritten, which increased the compliance threshold annually from July 2004 to December 2007. This change, authorized by the Medicare, Medicaid, and SCHIP Extension Act of 2007, was followed by a statutory change mandating the threshold at 60 percent. In addition, CMS issued another comprehensive regulatory change to the Medicare IRH/U coverage criteria effective January 1, 2010, and to the classification criteria in the FY 2012 IRF-PPS Final Rule. SNFs have gone under some legislative and regulatory changes as well over the last several years which, if not accounted for, could skew the readmissions data inappropriately. For example, CMS made changes to the use of group and concurrent therapy services as well as modified the Minimum Data Set (MDS), the assessment tool SNFs utilize. There is a bit of a delayed effect with such massive changes. Hence, the data analysis should include multiple years.

Second, we recommend that in addition to claims data, patient-specific data also be utilized.

Third, we suggest that the data be split by type of provider and that additional provider-specific data be considered, including characteristics such as being hospital-based or a rural provider.

B. Inclusion and Exclusion Criteria

The measure justification document developed by RTI lists a series of exclusions from the denominator including patients for which the primary diagnosis for the preceding hospital stay was for rehabilitation and the fitting or adjustment of a prosthesis. We believe that such admissions should be included in the denominator.

> *Exclusion 8 – SNF Stays where the patient's principle diagnosis during their proximal hospitalization was for "rehabilitation care; fitting of prostheses and for the adjustment of devices.*
> *Very few patients' prior proximal hospitalization involved rehabilitation care (n=1,979 [0.07%]), of which 17% were readmitted within 30 days, compared to 21.3% of patients without a principle diagnosis of rehabilitation care. These patients were so few in number that a facility analysis was not informative.*

C. Definition of Readmissions

Yale conducted an analysis to define planned readmissions that would be excluded from the measure. It defined them as a readmission in which one of 35 specified procedures occurred and those for maintenance chemotherapy or rehabilitation. Admissions for acute illness or for complications of care are not considered planned. The study then identified readmissions as acute or non-acute by observing the principal discharge condition. Many of the identified diagnoses are seen in rehabilitation; although, some not as frequently, such as treatment for a hysterectomy or lumpectomy. We recommend other conditions should be added to this list, such as planned surgery to close a flap due to a severe pressure ulcer, spinal stenosis implants, PEG or IVC filter placement, endarterectory, close of a crainiotomy site, total joint revision, and others.

D. Observation Window

The observation window is usually the period of time that will be included in the definition of a readmission. The most commonly discussed window is readmission within 30 days of discharge from the acute care hospital. We have no objection to the observation window as established.

E. Stratification of Cases

All readmissions should not be viewed as one large group on the assumption that they are homogeneous. Instead, we recommend stratifying readmissions patients by several factors. Doing so would provide a finer description of the types of readmissions cases and their circumstances and may facilitate the identification of any patterns or trends. In addition, different groups have different risk factors associated with their readmissions. It appears RTI sought to address several issues regarding stratification on its risk adjustment utilizing a surgical/medical split and examining individual and multiple comorbidities.

F. Risk Adjustment

AMRPA strongly believes that proper risk adjustment is mandatory with respect to these measures. We commented on this point in our December 2, 2010, letter to CMS (attached for reference). Such adjustment is necessary to assure that any quality measure reflects the true picture of the provider reporting data on the measures. In addition, it is particularly critical to rehabilitation patients given their variability and complexity. For example, no two strokes are the same. Multiple factors can be included for risk adjusting and include demographics such as age, gender, and living status; medical status including comorbidity, medical condition or diagnosis; functional ability including self-care, mobility, and cognitive; other severity factors; and case mix adjustment. We note that RTI used several of these factors in its approach to case mix adjustment.

AMRPA believes that risk adjusting outcomes is more challenging than risk adjusting other clinical results. At the outset, characterizing rehabilitation interventions is frequently difficult. Furthermore, outcomes are diverse and depend on a myriad of factors, including patients' physical and cognitive abilities, underlying medical diseases, sensory and emotional factors, willingness to participate in care and supportive environments.

We appreciate that RTI has recognized the importance that age, post-acute length of stay, ICU stay, and prior diagnosis and comorbidities in its model. We note, however, that family and support status play a direct role in whether a patient is readmitted to the acute hospital after SNF discharge. For example, studies show that a male patient is more likely to be discharged home if he is part of an intact couple. The presence of an involved family, caregiver, or other supports or support system plays a large role in discharge site decisions, almost from the point of the admission. They can also affect a readmission in that if they are present they may help the patient make the necessary follow-up appointment; help the patient physically get to the appointment, and make the next follow-up appointment; follow-up with therapy at home, help manage medications; assure community transportation is available, among other mechanisms of support.

Development of a Readmissions Measure for SNFs is Long Overdue

SNFs have significantly higher readmission rates when compared to many of their post-acute care colleagues. As noted in the support materials for the development of this measure and many stakeholders, including the Medicare Payment Advisory Commission (MedPAC), readmission rates for SNFs should be addressed. In a report issued by MedPAC in March 2013, the Commission noted the readmission rate for all SNFs was 19.2%. Freestanding SNFs' readmission rate was even higher at 19.8%. In contrast, the readmission rate for IRH/Us is much lower at 12%. In a 2012 report, MedPAC Commissioners recommended reducing payments to SNFs with high-risk adjusted rates of rehospitalizations. In the support materials for the development of this measure, RTI notes that studies have shown that approximately 78% of SNF readmissions to acute care hospitals were deemed

potentially avoidable. Given these factors, we encourage CMS to develop a readmission measure for SNFs as soon as possible to ensure Medicare beneficiaries receive high quality care and avoid unnecessary readmission to the hospital which increases costs and the likelihood of additional medical complications. We applaud SNFs for working to identify readmissions reduction strategies. A readmission measure for SNFs complements this effort.

Conclusion

In closing, we appreciate CMS' recognition of this critical quality improvement need. We remain committed to working with CMS to ensure the development of a readmission measure balances the need for improved quality of care for Medicare beneficiaries while minimizing provider burden. If you have any questions, please do not hesitate to contact Sarah Warren (swarren@amrpa.org) or Carolyn Zollar (czollar@amrpa.org) at 202-223-1920. Thank you for your consideration of our comments.

Sincerely,

Marsha Lommel, MA, MBS, FACHE
Chair, AMRPA Board of Directors
President and CEO, Madonna Rehabilitation Hospital

APPENDIX C

Post-Acute Care Reform: A Comparison of Various Proposals Affecting All Providers (Prepared by Patton Boggs LLP)
(Note: all savings estimates available are shown in parenthesis)

Source[i]	Home Health Agencies	Inpatient Rehabilitation Facilities	Long Term Care Hospitals	Skilled Nursing Facilities	Generally Applicable
Simpson-Bowles Commission, "The Moment of Truth"[28]	1) Accelerate ACA changes to reimbursements to incorporate productivity adjustment beginning in 2013 and phase in rebasing the home health prospective payment system by 2015 instead of 2017 ($2 billion in 2015, $9 billion through 2020).				1) Aggressively implement and expand payment reform pilots, including bundling for post-acute care services. Also pursue the introduction of downside risk to bundled payment pilots. 2) Implement cost-sharing reforms that prohibit first dollar Medigap coverage ($4 billion in 2015, $9 billion through 2020).
Simpson-Bowles, "A Bipartisan Path Forward to Securing America's Future"[29]	1) Institute value-based purchasing.	1) Equalize payments between rehab treatments provided in different settings. 2) Restore the 75% Rule for inpatient rehab facilities.		1) Institute value-based purchasing.	1) Move towards bundling for more providers. 2) Cost-sharing reforms that prohibit first dollar coverage. 3) Reduce the annual growth in payments to SNFs, IRFs, LTCHs, and Home Health.

[28] The National Commission on Fiscal Responsibility and Reform, "The Moment of Truth," (December 2010), available at: http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf.
[29] Moment of Truth Project, "A Bipartisan Path Forward to Securing America's Future," (April 2013), available at: http://www.momentoftruthproject.org/sites/default/files/Full%20Plan%20of%20Securing%20America's%20Future.pdf.

Source[i]	Home Health Agencies	Inpatient Rehabilitation Facilities	Long Term Care Hospitals	Skilled Nursing Facilities	Generally Applicable
					(All post-acute care payment reforms expected to save $70 billion through 2023).
Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options"[30]	1) Charge Medicare beneficiaries a copayment amounting to 10% of each home health episode ($14 billion from 2012-2016, and $40 billion from 2012-2021).			1) Impose a copayment for each of the first 20 days of care in a skilled nursing facility ($8 billion from 2012-2016, and $21 billion from 2012-2021).	1) Modify cost sharing for Medicare beneficiaries; bar or limit Medigap policies from paying some or all cost sharing expenses; combining the above two options.
Office of Management and Budget, "Living Within Our Means and Investing in the Future"[31]	1) Introduce home health copayments of $100 per episode with 5 or more visits not preceded by a hospital or other post-acute care stay ($400 million).	1) Equalize payments for certain conditions commonly treated in IRFs and SNFs ($4 billion). 2) Reinstate the 75% Rule ($3 billion).		1) Reduce SNF payments by up to 3% beginning in 2015 for facilities with high rates of preventable hospital readmissions ($2 billion).	1) Adjust payment rate updates in 2014-2021 for post-acute care providers ($32 billion).
MedPAC, "Moving forward from the	1) Copayment for home health episode ($4	1) Provide no update to IRFs in 2012 ($1	1) Provide no update to LTCHs in	1) Rebase payments to SNFs ($23 billion).	1) Apply readmissions policy to SNFs, HH, LTCHs, and IRFs

[30] Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," (March 2011), available at: http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf.

[31] Office of Management and Budget, "Living Within Our Means and Investing in the Future: The President's Plan for Economic Growth and Deficit Reduction," (September 2011), available at: http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/jointcommitteereport.pdf.

Source[i]	Home Health Agencies	Inpatient Rehabilitation Facilities	Long Term Care Hospitals	Skilled Nursing Facilities	Generally Applicable
sustainable growth rate (SGR) system"[32]	billion). 2) Rebase home health in 2013 and provide no update in 2012 ($10 billion).	billion). 2) Reinstate the 75% Rule ($3 billion).	2012 ($1 billion).		($4 billion).
MedPAC, "March 2013 Report to the Congress: Medicare Payment Policy"[33]	1) The OIG should conduct medical review activities in counties with aberrant home health utilization. 2) Begin a two-year rebasing of home health rates, and eliminate the market basket update. 3) Rely on patient characteristics to set payment for therapy and nontherapy services, no longer using the number of therapy visits as a payment factor. 4) Establish a per-episode copay for home health	1) Eliminate the update to payment rates for IRFs in 2014.	1) Eliminate the update to the payment rates for LTCHs in 2014. 2) MedPAC is studying the LTCH payment system and has noted that reimbursements continue to exceed costs, creating large margins. Because of this, MedPAC has recognized a possible need for reform of the LTCH payment system.	1) Revise the SNF prospective payment system and rebase rates. Payments for therapy services should be based on patient characteristics, not services provided. Payments for nontherapy ancillary services should be made through a separate component established to adjust for differences in patients' needs of these services. Add	1) Introduce one payment bundle for all post-acute care following hospitalization. 2) A common assessment instrument and single-payment system across institutional settings. 3) Risk-adjusted, outcomes-based quality measures that could be used to tie payments to outcomes. 4) Expand readmission policies to post-acute settings.

[32] Medicare Payment Advisory Commission, "Moving forward from the sustainable growth rate (SGR) system," (October 2011), available at: http://www.medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf.

[33] The Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," (March 2013), available at: http://www.medpac.gov/documents/Mar13_EntireReport.pdf.

Source[i]	Home Health Agencies	Inpatient Rehabilitation Facilities	Long Term Care Hospitals	Skilled Nursing Facilities	Generally Applicable
	episodes that are not preceded by hospitalization or post-acute care use.			an outlier policy. No update during year of revision, then institute 4% reduction in payments.	
Health and Human Services, "Fiscal Year 2014 Budget in Brief"[34]	1) Introduce home health copayments for new beneficiaries of $100 per episode, for episodes with five or more visits not preceded by a hospital or inpatient post-acute stay, starting in 2017 ($730 million savings).	1) Reinstate the 75% Rule ($2.5 billion). 2) Equalize payments for certain conditions commonly treated in IRFs and SNFs ($2 billion).		1) Reduce Medicare payments by 3% to SNFs with above-average readmission rates, beginning in 2017 ($2.2 billion).	1) Reduce the market basket updates for IRFs, LTCHs, SNFs, and home health agencies by 1.1% from 2014 to 2023 ($79 billion). 2) Bundled payments for IRFs, LTCHs, SNFs, and home health agencies for at least half of the total payments ($8.2 billion).
National Coalition on Health Care, "Curbing Costs Improving Care: The Path to an	1) Rebase home health payments to more accurately reflect costs and freeze them for 2012 ($10 billion).			1) Rebalance SNF prospective payment system incentives to reimburse adequately for non-therapy	1) Expand the Acute Care Episode bundling program to include post-acute care. 2) Expand Medicare payment penalties for

[34] Department of Health and Human Services, "Fiscal Year 2014 Budget in Brief: Strengthening Health and Opportunity for All Americans," (2013), available at: http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf.

Source[i]	Home Health Agencies	Inpatient Rehabilitation Facilities	Long Term Care Hospitals	Skilled Nursing Facilities	Generally Applicable
Affordable Health Care Future"[35]	2) Pre-payment review: require cross-checks on services before issuing reimbursement for services more susceptible to fraud; examine claims for home health services more closely.			ancillary services, and reduce incentives to provide unnecessary levels of rehabilitative services. 2) Rebase SNF payments to more accurately reflect costs ($23 billion).	avoidable complications and potentially avoidable readmissions to post-acute and long-term care providers. 3) Reduce reimbursement for post-acute care providers with high rates of risk-adjusted preventable readmissions ($4 billion).
UnitedHealth, "Medicare and Medicaid: Savings Opportunities from Health Care Modernization"[36]				1) Use a post-acute transition intervention program for SNFs ($7 billion; may add home health and community services costs).	1) Encourage adoption of payment reforms including performance incentives, bundled payments, shared-savings and shared risk arrangements, and capitation.
Center for American Progress, "The Senior Protection Plan: $385 Billion in Health Care Savings	1) Expand bundled payments under the Acute Care Episode Program and include related post-acute care	1) Expand bundled payments under the Acute Care Episode Program and include related post-acute		1) Reduce Medicare payments to SNFs with high rates of rehospitalization; impose a 3% penalty	1) Accelerate the use of bundled payments. 2) Prohibit Medigap coverage of the first $500 of costs for beneficiaries with

[35] National Coalition on Health Care, "Curbing Costs Improving Care: The Path to an Affordable Health Care Future," (November 2012), available at: http://www.nchcbeta.org/wp-content/uploads/2012/05/NCHC-Plan-for-Health-and-Fiscal-Policy.pdf.

[36] UnitedHealth Center for Health Reform and Modernization, "Medicare and Medicaid: Savings Opportunities from Health Care Modernization," (January 2013), available at: http://www.unitedhealthgroup.com/~/media/UHG/PDF/2013/UNH-Working-Paper-9.ashx.

Source[i]	Home Health Agencies	Inpatient Rehabilitation Facilities	Long Term Care Hospitals	Skilled Nursing Facilities	Generally Applicable
Without Harming Beneficiaries"[37]	provided up to 90 days after discharge. 2) Reduce excessive payments to home health providers, bring payments in line with actual costs ($15 billion). 3) Noting home health as a major source of improper payments by Medicare, would require Medicare to revoke billing privileges for any type of abusive or fraudulent billing.	care provided up to 90 days after discharge.		on facilities with above-average readmission rates, counting readmissions up to 30 days after discharge ($1.4 billion). 2) Reduce excessive Medicare payments to SNFs, align payments with actual costs ($15 billion).	incomes above 400% of the federal poverty level.
The Commonwealth Fund, "Confronting Costs"[38]					1) Accelerate bundled payment for post-acute care in public programs and from insurance on exchanges.
Senator Coburn, "Back In Black"[39]	1) Accelerate ACA changes to			1) Ensure proper payment for medical	1) Establish a combined annual deductible of $550

[37] Center for American Progress, "The Senior Protection Plan: $385 Billion in Health Care Savings Without Harming Beneficiaries," (November 2012), available at: http://www.americanprogress.org/wp-content/uploads/2012/11/SeniorProtectionPlan.pdf.

[38] The Commonwealth Fund Commission on a High Performance Health System, "Confronting Costs: Stabilizing U.S. Health Spending While Moving Toward a High Performance Health Care System," (January 2013), available at: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2013/Jan/1653_Commission_confronting_costs_web_FINAL.pdf.

[39] Senator Tom Coburn, "Back In Black: A Deficit Reduction Plan," (July 2011), available at: http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=413f351a-2588-4017-ad8a-99891e956bc6.

Source[i]	Home Health Agencies	Inpatient Rehabilitation Facilities	Long Term Care Hospitals	Skilled Nursing Facilities	Generally Applicable
	reimbursements to incorporate productivity adjustment beginning in 2013 and phase in rebasing the home health prospective payment system by 2015 instead of 2017 ($2 billion in 2015, $9 billion through 2020).			equipment during nursing home stays.	for Medicare and institute a 20 percent coinsurance on health spending above the deductible. 2) Prohibit Medigap coverage on first $500, limit Medigap cost-sharing to 50% of the next $5,000.
Representative Cantor, "Proposal for Health Care Savings"[40]					1) Reform post-acute care payments/cost sharing for SNFs and home health ($14 to $26 billion). 2) Prohibit first dollar Medigap coverage.
Lieberman/Coburn Proposal, "A Bipartisan Plan to Save Medicare & Reduce Debt"[41]	1) Accelerate ACA changes to reimbursements to incorporate productivity adjustment beginning in 2013 and phase in rebasing the home health prospective payment				1) Establish a combined annual deductible of $550 for Medicare and institute a out-of-pocket maximum of $7,500. 2) Prohibit Medigap coverage on first $550, limit Medigap cost-sharing to

[40] Eric Cantor, "Proposal for Health Care Savings," (July 2011), available at: http://thehill.com/images/stories/blogs/healthwatch/cantormed.pdf.
[41] Lieberman/Coburn Proposal Summary, "A Bipartisan Plan to Save Medicare & Reduce Debt," (June 2011), available at: http://www.coburn.senate.gov/public//index.cfm?a=Files.Serve&File_id=1ea8e116-6d15-46ba-b2e0-731258583305.

Source[i]	Home Health Agencies	Inpatient Rehabilitation Facilities	Long Term Care Hospitals	Skilled Nursing Facilities	Generally Applicable
	system by 2015 instead of 2017 ($2 billion in 2015, $9 billion through 2020).				50% between $550 and $7,500.

[i] Other proposals that were reviewed, but do not contain specific post-acute care reforms, include:

Paul Ryan Budget Proposal, "The Path to Prosperity: Restoring America's Promise," (April 2011), available at: http://budget.house.gov/uploadedfiles/pathtoprosperityfy2012.pdf.

Gang of Six Proposal, "A Bipartisan Plan to Reduce Our Nation's Deficits," (July 2011), available at: http://i2.cdn.turner.com/cnn/2011/images/07/19/a.bipartisan.plan.to.reduce.our.nations.deficits_final.pdf.