Policy Council Document
September 28, 2006
Post-Acute Care Reform Plan

Introduction

In May of 2005, the CMS Administrator formed the Policy Council to serve as a vehicle for the Agency's senior leadership to develop strategic policy directions and initiatives to improve our nation's health care system. One of the Council's first priorities was to develop a plan for post-acute care (PAC) reform. The Council developed a set of post-acute care reform principles and based on these principles developed a vision for post-acute care to guide current and future reform activities.

The Deficit Reduction Act (DRA) of 2005 was signed into law on February 8, 2006. Section 5008 of the DRA mandated a demonstration that supports post-acute care payment reform and is consistent with the Agency's vision for post-acute care. Implementation of the DRA demonstration thus became a key element of the Agency's strategy for PAC reform.

This document presents CMS' post-acute care reform plan. It describes: the current problems in the post-acute care system; CMS' principles and vision for post-acute care reform and various short and medium-term steps toward that goal.

Overview of the Current Problems in the Post-Acute Care System

Medicare currently covers PAC services in the following provider settings: Skilled Nursing Facilities (SNFs), home health (HHA), Long-Term Care Hospitals (LTCHs) and Inpatient Rehabilitation Facilities (IRFs).[1] To date, Medicare's PAC benefits and payment policies have focused on phases of a patient's illness as defined by a specific site of service, rather than on the characteristics or care needs of the beneficiary. Thus, payments across PAC settings may differ considerably even though the clinical characteristics of the patient and the services delivered may be very similar.

Currently each of the PAC provider settings has its own prospective payment system. Three of these payment systems rely on standardized data collected by providers using different assessment instruments (e.g., MDS 2.0, OASIS, and IRF-PAI) developed for multiple purposes, including assessment, quality improvement, and payment. However, the information is collected in different data formats, which are often not compatible and make it difficult to readily compare beneficiaries and their use of items and services across PAC settings. No assessment instrument is mandated for LTCHs. (Please see Attachment A for additional background information on the existing PAC assessment instruments and payment systems.)

Principles for Post-Acute Care Reform

As a first step in addressing the current problems in the post-acute care system, the PAC Workgroup developed a set of principles for reform which were approved by the Policy Council. These principles are summarized below:

[1] PAC services are also provided in other settings such as hospital outpatient departments, CORFs, free-standing outpatient therapy practices, inpatient psychiatric facilities, and through the hospice benefit. This paper, however, focuses on PAC services provided through SNFs, HHAs, IRFs and LTCHs.

- Increasing consumer choice and control of PAC services by Medicare beneficiaries, their family members and caregivers.
- Providing high-quality PAC services in the most appropriate setting based upon patient needs – which requires getting patients into the right PAC setting at the right time, as well as measuring patients' progress and the quality of care provided in PAC settings.
- Developing effective measures (including process measures) in order to drive the PAC system toward the delivery of high-quality care in the most effective manner and, thus, improve payment efficiency.
- Providing a seamless continuum of care for beneficiaries through improved coordination of acute care, post-acute care and long-term care services, including better management of transitions between care settings.

CMS' Vision for Post-Acute Care in the 21st Century

The central concept of CMS' vision for post-acute care is that the system will become patient-centered; that is, the system will be organized around the individual's needs, rather than around the settings where care is delivered. As such, the vision defines post-acute care in terms of the populations who need care. Specifically, post-acute care is care that is provided to individuals who need additional support to assist them in recuperating following an acute illness or serious medical procedure. A more beneficiary-centered system of post-acute care services has the potential to improve quality of care and continuity of care in a cost efficient way.

The person-centered post-acute care system of the future will:

- optimize choice and control of services;
- ensure that placement decisions are based on patient needs with both the patient and family receiving honest and useful information about the patient's situation and prognosis;
- provide coordinated, high quality care with seamless transitions between settings;
- reward excellence by reflecting performance on quality measures in payment;
- recognize the critical role of family care giving; and
- utilize health information technology.

Path to Achieving Reform

Demonstration Under Section 5008 of the Deficit Reduction Act of 2005 (DRA)

Section 5008 of the Deficit Reduction Act of 2005 (DRA) mandates a PAC payment reform demonstration. Under this provision, the Secretary is to establish a demonstration program by January 1, 2008 that would, for diagnoses or diagnostic conditions specified by the Secretary:

- use a comprehensive assessment at hospital discharge to help determine appropriate PAC placement based upon patient care needs and patient clinical characteristics;
- gather data on the fixed and variable costs for each individual and on care outcomes in various PAC settings; and
- use a standardized assessment instrument to measure functional status and other factors during treatment and at discharge across PAC settings.

The demonstration is mandated for a three-year period. It is to include a sufficient number of sites to ensure statistically reliable results. Within 6 months after the completion of the demonstration, the Secretary is required to report to Congress on the results and make appropriate recommendations. Six million dollars is made directly available from the Hospital Insurance trust fund for the costs of the demonstration.

CMS has developed a plan to implement the DRA demonstration (see Attachment B). The uniform assessment instrument that is being developed under the DRA demonstration will be comprehensive, inter-operable, and implemented on a internet-based platform. In addition to its use within the demonstration, the uniform assessment instrument will be made available for use in 2008 by hospitals outside of the demonstration on a voluntary basis as a tool for improving care transitions to PAC settings. The assessment and cost data collected under this demonstration will lead to comprehensive, site-neutral PAC payment reform.

Budget Proposals

The FY 2007 President's Budget included a proposal to reduce the excessive difference in payment between Inpatient Rehabilitation Facilities (IRFs) and Skilled Nursing Facilities for total knee and hip replacements. CMS will continue to look for opportunities to propose policies which move the program in the direction of our ultimate goal of site neutral payment for PAC services.

Pay-for-Performance Activities

CMS currently has activities underway with regard to pay-for-performance for both the home health and the SNF settings. For HHAs, in 2007 CMS will begin pay-for-reporting. HHAs that submit the required quality data (i.e, for 2007, CMS has proposed using 10 OASIS quality measures that are currently being reported through the CMS Home Health Compare website) would receive payments based on the full proposed home health market basket update of 3.1 percent for CY 2007. If a HHA does not submit quality data, the home health market basket percentage increase will be reduced by 2 percentage points to 1.1 percent for CY 2007. Pay-for-reporting will eventually transition to pay-for-performance. With regard to SNFs, CMS anticipates implementing a 3-year Nursing Home Value Based Purchasing Demonstration under which participating nursing homes will be offered financial incentives to provide high quality care and or to improve the level of care that they provide.

Electronic Health Records and Personally Controlled Health Records

Over the long term, interoperable, widely deployed Electronic Health Records will play a major role in coordination of post acute care. The creation of a uniform assessment instrument for all post-acute patients can be built into the functionality of an EHR, alleviating the need to reconfigure the data every time the data move to a new setting. Availability of clinical and functional status patient information across multiple settings will be the most immediate benefit. However, EHRs also have the potential to streamline the collection and reporting of quality data and to support a range of evidence based quality improvement initiatives. In the shorter term, Personally Controlled Health Records (PCHRs, or simply PHRs) will allow patients and their caregivers to take individual responsibility for the portability of their medical history. A portable, patient controlled PHR can be updated after each encounter, allowing the patient to take an active role in reducing the medical "paper chase."

Conclusion

In fiscal year 2005, Medicare spent $42 billion on post acute care services. Although this spending represents 13 percent of all Medicare benefit spending, the value that beneficiaries and tax payers are receiving is unclear. The post-acute care product is not well defined. Differences in assessment instruments make precise comparisons across settings difficult if not impossible. Optimal care transitions are hindered by the absence of a smooth flow of patient information from the acute to the post acute setting. Economic incentives resulting from the intricacies of the four separate payment systems interfere with the PAC placement decisions being made on a patient-centered basis.

With the implementation of the DRA payment reform demonstration, CMS will address both patient care and analytic needs through the development of a uniform patient assessment instrument to be used at hospital discharge and across PAC settings. Combining the patient assessment data and the facility cost data will provide the analytic input for PAC payment reform which will ultimately lead to a site neutral payment system. Incorporating pay for performance mechanisms into this new system will provide new incentives for providers to strive for excellence in the provision of PAC services. The uniform assessment instrument and the reformed payment system will improve care transitions and the overall quality of PAC care and foster PAC placement decisions that are patient-centered, reflecting patient needs.

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Attachment A: Background Information on Medicare's Current Post-Acute Care Payment Systems and Assessment Instruments

Medicare has four separate prospective payment systems for each post-acute care (PAC) provider setting. Three of these payment systems rely on standardized data collected by providers using assessment tools developed for multiple purposes, including assessment, quality improvement, and payment.

- All skilled nursing facilities perform patient assessments using a standard Minimum Data Set (MDS).
- All certified home health agencies perform patient assessments using the Outcome and Assessment Information Set (OASIS)
- All Inpatient Rehabilitation Facilities use the IRF Patient Assessment Instrument (IRF-PAI).

To date, Medicare's PAC benefits and payment policies have focused on phases of a patient's illness as defined by a specific site of service, rather than on the characteristics or care needs of the beneficiary. Thus, payments across PAC settings may differ considerably even though the clinical characteristics and care needs of the patient and the services delivered may be very similar.

Furthermore, while the existing assessment instruments used in PAC settings allow providers to collect data in a standardized way, even when providers collect similar information on a single patient, each instrument collects the information using unique metrics and stores the information in different data formats, which are often not compatible and make it difficult to readily compare beneficiaries and their use of items and services across PAC settings. For example, providers across Medicare sites of service commonly collect information on a patient's diagnosis. Some settings collect and store this information as a code while others store the same information as a checklist of conditions. Also, while all of the PAC assessment tools include measures relating to patients' functional status, cognitive status, diagnoses, and comorbidities, they differ considerably in terms of the timeframes covered, scales used to differentiate patients, and definitions of the measures. The following is a summary of some of the major differences between the current PAC assessment tools.

	MDS 2.0	IRF-PAI	OASIS
Post-Acute Care Setting	Medicare or Medicaid certified nursing homes, i.e., Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)	Inpatient Rehabilitation Facilities	Medicare-Certified Home Health Agencies
Frequency of Administration	Conducted close to (but not necessarily at) admission and periodically throughout the patient's stay – on days 5, 14, 30, 60, & 90 (but not at discharge)	Typically administered on the third day of the admission and at discharge	Routinely at admission, every 60 days, and discharge; Other assessments determined by change in patient health status
Timeframes Covered	Generally captures the patient's condition over the past 7 days recording the most support	Captures the patient's status on that day	Generally captures the patient's status within the last 24 hours; some

	MDS 2.0	IRF-PAI	OASIS
	needed during that time		functional status items capture status in the prior 14 days – records an assessment of ability rather than actual performance at time of assessment
Time Required to Complete	90 minutes	25 minutes	90 minutes – Start of Care (SOC) version; 60 minutes – Resumption of Care (ROC), Follow-Up (FU), Significant Change in Condition (SCIC), and Discharge (DC) versions; 15 minutes – Transfer version
Scales Used to Differentiate Patient Functionality and Acuity	3-6 point scale	7 point scale	3-5 point scale
Functional Status Definitions	Evaluates whether and how frequently the patient needed assistance to engage in a given task, such as walking or getting dressed, as well as the type of help involved (e.g., weight bearing or verbal encouragement)	Includes the distances walked Distinguishes what share of the dressing a patient performs	Records the patient's ability to walk safely, once in a standing position
Diagnosis and Comorbidity Definitions	Uses a checklist of diagnoses or comorbidities	Uses ICD-9 codes to record diagnoses or comorbidities	Requires the use of the highest level of specificity for all digits of the ICD-9 Does not require the use of all 5 digits of the ICD-9-CM code
Cognitive Status Definitions	Considerable variation, including whether the tools distinguish between short-term vs. long-term memory, how depression and delirium are evaluated, and the types of decisions patients are able to make		

Skilled Nursing Facilities (SNF) Per Diem Payments based on Resource Utilization Groups (RUG)

SNFs provide short-term skilled nursing and rehabilitative care to people with Medicare who require such services on a daily basis in a SNF setting after a medically necessary hospital stay lasting at least three days. SNFs use the Minimum Data Set 2.0 (MDS 2.0) instrument to obtain a comprehensive assessment of each resident's functional capabilities and help nursing home staff identify health problems.[2] The MDS captures health assessment data with the use of a

[2] http://www.cms.hhs.gov/quality/mds20/

checklist of conditions. SNFs receive per diem payments for each admission, which are case-mix adjusted using a resident classification system, Resource Utilization Groups (RUG) III, based on data from MDS 2.0 and relative weights developed from staff time data. Patients are classified into RUG-III groups based on need for therapy (i.e., physical, occupational, or speech therapy), special treatments (e.g., tube feeding), and functional status (e.g., ability to feed self and use the toilet). Patient status is reviewed periodically to update the RUG-III grouping.

Home Health Agency (HHA) 60-Day Episode Payments Based on National Rate

To qualify for Medicare home health visits, people with Medicare must be under the care of a physician, have an intermittent need for skilled nursing care or need physical therapy/speech therapy, or have a continuing need for occupational therapy. The beneficiary must be homebound and receive home health services from a Medicare approved HHA. Health assessment information is captured by HHAs in the Outcome and Assessment Information Set (OASIS). Under the home health PPS, Medicare pays higher rates to home health agencies to care for beneficiaries with greater needs. Payment rates are based on relevant data from patient assessments using the OASIS instrument. Home health services are measured in 60-day units called episodes and the amount of payment for an episode is the national base rate, adjusted for case-mix and for labor/wages in the area where the patient resides. The base payment covers the cost of visits and routine supplies, which is based upon a model with 1997 costs. The standardized payment amount model is updated annually using the home health market basket percentage.

Inpatient Rehabilitation Facility (IRF) Per Discharge Payments Based on Case-Mix Groups

For classification as an IRF, a percentage of the IRF's total patient population during the IRF's cost reporting period must match one or more of thirteen specific medical conditions. Currently, CMS is in the midst of a multi-year transition. On July 1, 2005, CMS began requiring that 60 percent of the total population match the thirteen medical conditions. Health assessment data are captured at IRFs with the use of the IRF Patient Assessment Instrument (IRF-PAI), which utilizes a 5 digit ICD-9 code. Payments under the IRF PPS are made on a per discharge basis. Under this system, payment rates are based on case-mix groups (CMGs) that reflect the clinical characteristics of the patient and the anticipated resources that will be needed for treatment.

Long-Term Care Hospital (LTCH) Per Discharge Payments based on Diagnosis Related Groups (LTC-DRGs)

To qualify as a LTCH, a facility must have an average inpatient length of stay greater than 25 days. These hospitals typically provide extended medical and rehabilitative care for patients who are clinically complex and may suffer from multiple acute or chronic conditions. Services may include comprehensive rehabilitation, respiratory therapy, cancer treatment, head trauma treatment, and pain management. LTC-DRGs are used under the LTCH PPS to classify patients into distinct diagnostic groups based on clinical characteristics and expected resource needs. LTC-DRGs, are based on the existing DRGs used under the hospital inpatient PPS that have been weighted to reflect the resources required to treat the medically complex patients treated at LTCHs. Unlike other post-acute care settings, there is no existing requirement for an assessment instrument for the LTCH setting.

Attachment B:
Timeline for Implementation of DRA Section 5008 Demonstration and Related PAC Reform Activities

Timeframe	DRA Demonstration – Assessment Instrument	DRA Demonstration – Payment Reform	Other Use of Assessment Instrument
Late October , 2006	Award contract for development of assessment instrument		
Early December, 2006		Award contract for: development of cost data collection tool; collection of assessment and cost data; and analysis of data.	
December 2006 – July 2007	Obtain Industry and expert input on Assessment Instrument through Town Hall Meeting and Technical Advisory Panels		
January 2007	Award contract for development of internet application for the assessment instrument		
Spring 2007	Begin recruiting providers for DRA demonstration		
Summer 2007	Alpha and beta testing of assessment instrument and application		
Jan 2008	Demonstration begins in one market		
April 2008	Full scale implementation of demonstration begins		Possible use of assessment instrument by providers outside of the demonstration on voluntary basis
July 2011	Report on demonstration delivered to Congress		