# The Continuing Care Hospital Pilot: Recommendations for Implementation

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THE CONTINUING CARE HOSPITAL PILOT:

RECOMMENDATIONS FOR IMPLEMENTATION

Executive Summary

August 2011
THE CONTINUING CARE HOSPITAL PILOT TEST: RECOMMENDATIONS FOR IMPLEMENTATION

Executive Summary

Introduction
The Continuing Care Hospital (CCH) Pilot Test was enacted in Sections 3023 and 10308 of the Patient Protection and Affordable Care Act of 2010 (PPACA), Public Law (P.L.) 111-148. The American Medical Rehabilitation Providers Association (AMRPA) strongly supported its inclusion in the health care reform legislation and is pleased that it was included in the final law. The CCH concept provides an opportunity to develop a patient-centered care model in which the “silos” established by the variety of Medicare payment systems based on care setting are eliminated. Care under the CCH model is delivered based on need rather than setting, and there is an opportunity to realize cost savings due to efficiencies the CCH model would allow. Payment may also be more reflective of actual cost and resource use and not include the multiple costs associated with meeting the requirements of the current payment systems and transfers among care settings as is currently required.

In response to the passage of PPACA, AMRPA developed a position paper to establish a framework upon which the Centers for Medicare and Medicaid Services (CMS) may build the CCH Pilot Test. This position paper reviews the need for the CCH concept, its development, and the requirements of the statute. It also puts forth principles, issues and recommendations for how HHS/CMS might approach the pilot.

Background
The CCH represents both a new approach to the delivery of post-acute care and financing reform for the medical rehabilitation and complex medical services delivered by today’s inpatient rehabilitation hospitals and units (IRH/Us), hospital-based skilled nursing facilities (HSNFs) and long-term care hospitals (LTCHs). The Continuing Care Hospital (CCH) would organize care around the patient instead of the provider by consolidating all three levels of inpatient post-acute care into a single enterprise with a single payment system and single method for measuring quality. The CCH could be either real (all care levels in a common building) or virtual (all levels operated as a single entity, but in two or more physically distinct locations). The CCH is intended to enhance the quality of care patients experience by eliminating the physical and invented boundaries of the current hospital-based post-acute care system. It would result in reduced administrative costs to deliver complex medical and rehabilitation post-acute care, improve the cost-effectiveness of post-acute services, and enhance the quality of care received by patients.
The medical rehabilitation field was developed in the first third of the 20th Century by physicians who believed that there was more to health care than simply diagnosing and medically treating patients with serious permanent impairments. Over the years, physician-directed, hospital-based multidisciplinary teams devoted to the principles of rehabilitation evolved into the field of medical rehabilitation and, as we know it today, the IRH/U. The LTCH field evolved from treating TB and other chronic, medically complex diseases during a similar period. HSNFs also expanded starting with the onset of the DRGs in 1982. The post-acute sector grew with the advent of the inpatient PPS in 1983. With this growth has come confusion about how best to distinguish among the various post-acute facilities and the services they provide.

In March 2011, there were about 1,169 IRH/Us organized specifically to provide medical rehabilitation, over 15,700 skilled nursing facilities (SNFs) and over 430 long term care hospitals (LTCHs), which also provide medically complex care and some level of medical rehabilitation services to inpatients. Currently, each of these entities must meet specific conditions of participation, and, in some cases, specific additional criteria, under the Medicare program in order to be reimbursed. The plethora of coverage criteria and definitional standards regarding either the types of patients or processes of care in each of these post-acute care venues has raised concerns in policy circles that there are few objective standards or criteria by which to assign individual patients to specific settings. These factors point to a need to improve the post-acute care delivery system by focusing on patient-centered care. AMRPA proposed the creation of a Continuing Care Hospital to strengthen the delivery system with a focus on patient’s clinical needs.

The CCH model is a significant change in the delivery system for post-acute care and would also provide or coordinate home health and outpatient rehabilitation services for patients who need them after discharge. The CCH would operate under common management and hence could be an actual building (a hospital offering some or all three levels of service) or a virtual entity (an organization that provides under common management the three levels of service in more than one building or unit). A physician would make the admission decision regarding whether a patient should receive care within the CCH and determine which level of service the patient would need. Payment would be determined by the patient’s clinical and functional characteristics and the program resources needed to provide that care. Pilot test participants would be allowed to care for certain types of patients if they demonstrate the ability to provide care, as defined by law and regulation, meet specific patient care and patient safety standards, and demonstrate certain outcomes.

**Statutory Mandate**

The Secretary of the Department of Health and Human Services (HHS) is required to conduct a National Payment Program on Bundling and that “in conducting the pilot program the Secretary shall apply the provisions of the program so as to separately pilot test the continuing care hospital model.” The CCH pilot test has several specific requirements; however, all the other provisions of the national payment pilot on bundling appear to be applicable to the CCH pilot test and must be considered in its design.

**Principles**

Before analyzing the specific issues to be addressed in the CCH pilot, AMRPA recommends a number of guiding principles that must be met. These principles include:
1. Patients
   - The CCH pilot needs to be patient-centered.\textsuperscript{1} 
   - Service delivery should be organized to optimize meeting the needs of patients.
   - It must serve the needs of persons with disabilities, chronic conditions, and those with acute health problems. Hence, persons with functional loss must have access to medical rehabilitation and complex medical care.
   - Persons with medical problems associated with functional loss must have access to rehabilitative services to improve function and increase independence.
   - Any CCH model must provide patients with an adequate choice of providers, suppliers, and services.
   - The pilot should maximize outcomes and patient satisfaction.

2. Providers
   - Appropriate physician involvement, direction, and oversight are essential to the delivery of medical rehabilitation and complex medical care. This should be supported through the credentialing process.
   - Providers should deliver services commensurate with the intensity of the needs of patients.
   - Services delivered should be provided based on the best available clinical evidence and expert judgment.
   - Providers should be able to receive reasonable payment for delivering high quality care.
   - The pilot 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.

3. Payers
   - Cost-effective and cost-efficient care should be promoted.
   - Reimbursement must thoroughly account for all payments, costs, and resources associated with patient care.
   - The system should maximize administrative simplicity for providers and payers.

4. 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.
   - Quality measures selected should promote positive outcomes, avoidance of adverse events, and demonstrate effectiveness and efficiency of care.

5. Additional Criteria
   - The pilot should adjust adequately for environmental and social factors consistent with the World Health Organization International Classification of Function (WHO ICF).

\textsuperscript{1} Patient centered means the needs of the patient are the primary needs not those of institutions, professionals, payers or governmental programs.
The CCH should encourage an economically rational organization of service capacity.
Financial risk should be minimized.
The pilot should be sufficiently robust to be replicable as a national program.
The pilot should be budget neutral.

**Design Issues: Key Elements to Be Addressed in the CCH Pilot**

1. **Scope of Services to be Included in the CCH**
   The statute addresses the services provided during the CCH stay plus the 30 days post discharge. These services include those currently provided by IRH/Us, LTCHs, and HSNFs. Hence, they would include specialized physician and nursing care, extensive therapy services, and any other currently covered services. In addition, laboratory work, outpatient services, home health services, emergency services, and other diagnostic services currently recognized in the IRF, MS-DRG LTCH, and SNF PPSs would need to be included. The statute also states that payment will include other services such as care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities as determined by the Secretary. Durable medical equipment, orthotics, and prosthetics would need to be included unless they would continue to be paid on a different schedule based on the payment recommendations.

2. **Duration of the Episode/ Definition of the Episode**
   The duration of the EOC is stated in the statute as the CCH stay plus the 30 days post discharge from the CCH. As noted in the full position paper, numerous issues are involved in defining the stated EOC and in particular when a new EOC starts. For example, if a patient is readmitted to the acute hospital, and then returns to the CCH, then does a second EOC start? Or, if a patient is discharged from the CCH but during the 30 day period post discharge is readmitted to the acute care hospital and then readmitted to the CCH or returns to the setting from which they were admitted, the same question remains. Hence, clear entry and exit points would need to be defined.

3. **Coordination with Existing Medicare Benefits Package**
   The current discharge or per diem “episodes” are aligned with current Medicare regulations including days of care, deductibles and co-insurance. It is crucial that beneficiaries do not bear unintended additional costs with respect to co-insurance and co-payments in the CCH pilot test or a transition to the CCH from the current payment system. One approach is to re-evaluate the Medicare benefit package to ensure that the CCH EOC takes into account current Medicare Part A benefits, Medigap policies, and the transition from Medicare to Medicaid. Hence, as with the national bundling pilot, the CCH raises questions regarding how payment under the pilot may lead to changes in the Medicare benefits available to beneficiaries and their financial liability. These differences in coverage and beneficiary liability need to be considered and aligned in the pilot.

4. **Admission Criteria**
   Any patient who currently needs what are characterized as LTCH, IRH/U, or HSNF medical and rehabilitation services would be an appropriate patient for the CCH. Admission to the
CCH would depend on the status of the patient at discharge from the acute hospital or referral from the community. A preadmission screening would be conducted to determine if the patient meets the factors included in the admission criteria developed in detail in the full position paper.

5. **Common Patient Assessment Instrument/Method**

A common patient assessment instrument may be used to provide data for making admission and continued stay decisions. Such an instrument should not be a sole decision support tool nor used as the predictive model for admission or discharge. Such decisions must be made in conjunction with the observations and expertise of physicians with experience in treating patients with complex medical and medical rehabilitation needs, nurses, and therapists. AMRPA has developed specific criteria that any assessment tool selected for the CCH pilot test should meet as well as specific components that should be included in this assessment tool which are included in the full position paper.

AMRPA notes that current tools (IRF PAI, MDS 3.0, LTCH MS DRGs and UB forms) used to collect common data have been proven to be incompatible in content. The statute references the CARE tool, a cross-site instrument which has been used to collect data from all the sites of care in question, as a possible patient assessment instrument for determining the site of post-acute care. If the CARE tool is selected for the CCH Pilot test, the various versions of it need to be revised to meet the criteria established by AMRPA. CMS also needs to consider mechanisms to reduce the administrative burdens the CARE tool currently imposes. AMRPA has made suggested edits to the current version of the CARE tool to conform with the ICD-10 and the WHO ICF. An example is included in an appendix to the position paper.

6. **The CCH as the Accountable Entity: Provider Requirements**

   a. **Statutory Requirements**

   The statute establishes certain criteria prospective CCH candidates must meet for participation in the pilot. In addition, AMRPA has identified additional capabilities that a CCH, be it virtual or real, will need to demonstrate for purposes of the pilot including the following which are detailed further in the position paper:

   (i) Licensure
   (ii) Program Components
   (iii) Physical Space
   (iv) Professional Staffing
   (v) Quality Improvement
   (vi) Services Provided
   (vii) Services should maximize innovation and be based upon the best available clinical evidence
   (viii) Other Attributes such as
         (A) Dedication of hospital, physician, nurse, therapists’ etc. time to the pilot
         (B) Ability to deliver, or contract for, the entire bundle of services to be rendered
(C) Have clinical pathways and effective discharge planning capacities and case management within the CCH

(ix) Accreditation

b. Patient Clinical Criteria
Patients are described with the same parameters as are used for the acute hospital and followed to the CCH.

(i) Patients are characterized by the intensity and sophistication of the medical and nursing care required.
(ii) Patients are characterized by the degree of coordination of the multidisciplinary rehabilitation and medical teams required over the course of their care.
(iii) Patients are characterized by their level of volatility, change, and their needs over stated periods of time.
(iv) Medical and therapeutic supervision is required in order to change the plan of care as needed.
(v) The patient benefits from coordinated multidisciplinary care for their medical, therapy, and nursing needs during their care in the CCH and from less intense services toward the end of the EOC.

c. Patient Safety Standards
Patient safety is the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum. The statute requires that the CCH meet patient care and patient safety standards. Some standards are already included in the Conditions of Participation for Hospitals which AMRPA presumes all CCHs would meet since the initial intensity of care is at the hospital-level according to the statute. AMRPA recognizes there are other sources for these standards as well, including accrediting organizations such as the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities (CARF.)

7. Common Management
The statute requires that services provided to beneficiaries under the CCH pilot test must be provided by entities under common management. Common management may be accomplished through a partnership, professional corporation, limited liability company, joint venture, foundation, or nonprofit corporation. The managing head is an individual that exercises operational or managerial control. Common management will include a designated governing body, organized medical staff, a chief executive officer, and the form would be further defined by the CCH’s bylaws, rules, and regulations. In addition no physical component of the CCH could be more than 35 miles from another component.

8. Quality and Outcome Measurement
In the CCH, as in the national bundling pilot, it is critical that there be reporting of quality data and measurement of quality performance on quality measures. Such measurements should act to assure that patients are receiving the level of services and care their conditions

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require and that there is no stinting on care. At a minimum, such measures should be relevant to the population of patients, cover a broad scope of medical status and functional ability, be reliable and valid as measures, and be operationally feasible to use. As these measures are developed, CMS should take care to ensure that there is coordination with other CMS quality reporting initiatives to limit the administrative burden placed on providers and that these programs maximize quality improvements.

The statute is clear that the Secretary is to establish certain quality measures for care that the CCH is to meet. The statute requires the pilot(s) to include developing nine categories of measures:

   a. functional status improvement;
   b. reducing rates of avoidable hospital readmissions;
   c. rates of discharge to the community;
   d. rates of admission to an ER after hospitalization;
   e. incidence of acquired infections;
   f. efficiency measures;
   g. measures of patient centeredness of care;
   h. measures of patient perception of care;
   i. Other measures including measures of patient outcomes determined appropriate by the Secretary; and
   j. Long term measures of integration into former life roles and society

These measures must be risk adjusted.

Once the data are collected over a period of years, performance measures would allow development of incentive payment methods to reward those institutions that constantly achieve better risk-adjusted medical and functional outcomes. Such performance incentives can be developed in a budget neutral manner. Development of performance measures would be coordinated with those entities that have already been exploring the issue. AMRPA includes a list of measures for CMS’s consideration in the full position paper.

9. Payment Methodology
The CCH payment methodology is presumed to be a bundled payment for the EOC. The unit of payment is the EOC in contrast to a per discharge or per diem approach. The Secretary is to develop the payment method(s) which may include bundled payment or bid payment. The law says that payment is not to exceed the current program expenditures. AMRPA does not support a bid payment. In addition, AMRPA recommends that the pilot be conducted in two phases. The first phase would establish data on the inpatient stay. The second phase would include the complete EOC (e.g. the inpatient stay plus 30 days).

10. Payment Considerations
   a. General Discussion and Treatment of Beneficiary Costs
The CCH model is intended to create incentives to treat a wide range of patients with special care needs. Payment should include a standard payment amount per patient EOC and include risk adjustment to acknowledge patient differences and variability in cost. It
should also be adjusted for outliers including patients that have longer or shorter than average episodes of care. It is critical that all payments, costs, and resources used related to the EOC be included for purposes of calculation for each episode. It is presumed the EOC payments are to include Part B payments, other than physician services. In addition, because of the structure of the EOC, this accounting should include those costs currently borne by the patients, such as co-pays and deductibles.

AMRPA is concerned that appropriate data are not available upon which to base a revised payment system. Therefore, it recommends that the demonstration project be implemented in two phases. The first phase would establish data on the inpatient stay. The second phase would include the complete EOC (e.g. the inpatient stay plus 30 days). During Phase II CMS should collect data regarding CCH utilization and payments to predict utilization from comparable patients treated in conventional silos.

b. Special Payment Adjustments

AMRPA recommends that the CCH pilot include special payment policies and adjustments including:

(i) High cost outliers
(ii) Carve outs for costs not related to the conditions for which EOC treatment is given, DME and other treatments (e.g. dialysis, non related hospital readmissions)
(iii) The demonstration project be implemented in two phases due to the lack of data regarding the cost of a CCH stay that includes multiple levels of post-acute care. The first phase would establish data on the inpatient stay. The second phase would include the complete EOC, e.g. the inpatient stay plus 30 days.
(iv) During Phase II CMS should collect data and CCH utilization, and payments to predicted utilization from comparable patients treated in conventional silos.

c. Readmissions

Additionally, the pilot should address patients discharged from the CCH who are readmitted to the acute hospital within the 30 days post discharge from the CCH. Any payment adjustment should not be imposed if the condition was unavoidable or unrelated to the original condition requiring admission to the CCH. If the readmission was related to the original condition, then the EOC payment may be reduced by the same percentage by which an acute care readmission would be reduced.

d. Physician Services

The statutory language for the CCH appears equivocal about whether or not physician services are to be included in the bundle. The law requires that the payment methodology for the national bundling pilot program, and possibly the CCH program, is to include applicable services, which include physicians’ services.

e. Provider Adjustment Factors

Certain cost variations not within providers’ control should also be accommodated for in the payment system. They may be a function of governmental (state, local, or federal) requirements, geography, or unique system delivery factors. AMRPA recommends that the payment methodology include adjustments for the factors listed above.
f. **Payment for Services That Extend Beyond the EOC**
   The pilot would also have to address treatment of, and payment for, services provided outside of the CCH episode of care. The current payment systems would remain in place for people served outside the EOC timeframe who might need acute care that does not fall within the readmissions framework, including in community-based SNF, nursing home, assisted living services, home health, hospice, or outpatient services.

g. **Case Mix Adjustment**
   The CCH outcomes measures and payment must be case mix adjusted for each EOC’s costs. Such adjustment factors include function, medical severity, age, gender, and social factors such as social support at home or in the community, socioeconomic status, and language.

h. **Quality Incentive Payments**
   The pilot should provide quality incentive payments for reporting the quality data during the pilot. Once a baseline of quality data is collected then benchmarks can be established from which to develop the incentive payments.

11. **EOC Patient Classification System**
   The ideal CCH model requires a patient classification system that accounts for patient characteristics and resource utilization during the EOC. A traditional patient classification system could be used for purposes of outcomes measurement as well as payment. For example, in the IRF PPS, the IRF PAI is used to collect data about patients and categorize them into case mix groups (CMGs). CMGs are based on several factors including age, motor and cognitive status on admission, and co-morbidities. They are then tied with payment information (Medicare claims and cost reports) to create CMG weights using the hospital specific relative value weights methodology. Payment is per case per discharge. AMRPA provides full details as to the types of data that should be collected in the patient assessment and how this information can be used to adjust payment in the full position paper.

   However, while a patient classification system for the EOC may be ideal, the variability in this patient population suggests it would take several years to develop a viable system to predict resources and cost. Hence, during the pilot CMS may want to continue payment based on the FFS models with a shared savings incentive and anticipate moving to bundled payment by condition by EOC and risk adjusted over the time of the pilot.

12. **List of Medical and Rehabilitation Services**
   The law states that medical and rehabilitation services provided by IRH/Us, LTCHs, and HSNFs are included in the CCH EOC.

13. **Statutes and Regulations**
   In conducting the CCH pilot CMS has the authority to waive Medicare and other regulations and parts of the statute. The various laws and regulations need to be examined for these purposes. A list of these is included as an appendix to the position paper. Potential waivers
critical to the success of the pilot project include but are not limited to the IRH/U 60% rule, the IRH/U three hour rule, the LTCH 25 day LOS rule, and the SNF three day rule.

14. Evaluation Criteria for the Pilot
AMRPA makes specific recommendations in the full position paper regarding evaluation criteria for the pilot including that it should be nationally representative of the types of services and providers encompassed by the statute, the sample size of patients must be nationally representative of the types of case, payment and resources used in all three levels of care, and it must cover both the real and virtual concepts.

15. Other Considerations
Other factors CMS should take under consideration in the design of the pilot include:
   a. Pay providers to participate.
   b. Common electronic platform or platforms that can communicate across former sites of care are necessary.
   c. Include a hold harmless clause in the provider participation agreements for the pilot.

Special Considerations for the Virtual CCH
While many of the considerations for the real and virtual CCH models are similar, there are some that are quite different for the virtual model. A common ownership or management entity would be identified as the provider. Admission and management of the patient would be through a single point of entry. The provider would continue to be responsible for, and be paid based on, the EOC and receive full payment based also on the outcomes measures.

Steps Required to Implement the CCH
The steps outlined below are those needed to be taken to investigate the various design issues.

1. Data Base Design
   a. Services
      Define the medical and rehabilitation services provided by IRH/Us, LTCHs, and HSNFs. Describe the volume and types of services, the costs, and payments. Also, determine the scope of physician services to be included. Include data on outpatient therapy services in all settings. CMS should also collect data on patients who continue to receive Medicare services after the EOC has ended.

   b. Patient Characteristics
      Collect data on attributes such as diagnosis, function on admission, function on discharge, age, sex, race, co-morbidities, LOS, and social and personal factors. Also track discharge destinations, death rates, and planned and unplanned readmissions.

   c. Collection Instrument/Codes
      Review the inpatient and outpatient CARE tools and the AM-PAC tool. Revise as needed based on the current experience from the PAC PRD, based on the principles and criteria outlined in the position paper, and based on the suggested revision to the CARE tool developed by AMRPA. CMS should also consider collecting the data using the ICD-10 – CM and /or ICF nomenclature.
d. **Payment /Costs/Resource Use**
   The database also has to account for all payments and costs for each potential definition of the EOC. CMS should also collect payment and cost data on patients who continue to need services after the EOC has ended.

e. **Refine the Data Modeling Various EOC Definitions**
   This step includes looking at the definitions of the EOC such as whether a defined EOC of the CCH stay plus the 30 days post discharge should be “prorated,” “fixed,” or take other approaches. Both the prorated and fixed approach were explored by RTI in the PAC EOC study.

2. **Analyze the Feasibility of Creating Patient Episodes of Care Including Risk Adjustment**
   From these data, CMS should analyze the feasibility of creating new patient episodes of care from the patient characteristics collected. Severity would be included in the creation of the groups to address the impact of single or multiple co-morbidities in lieu of tiers in order to reflect medical acuity and to provide for initial risk adjustment.

   A key challenge in developing the EOC is the variability and range in these patients and their costs. Hence, creating homogenous groups (in terms of patient characteristics and costs) with strong resource predictability and a payment to cost ratio of one is difficult and could result in a large number of groups which would look like a string of LTCH, MS DRGs, CMGs, and RUGs. AMRPA proposes a phased process to address this challenge.

3. **Create Patient Episode of Care Weights**
   Match the new patient episode groups with Medicare cost reports, claims data, any other information and the additional data from the Cost Resource Utilization tool used in the PAC PRD to create new “Patient Continuing Care Hospital Care Episode of Care Groups (CCHCGs).” This should result in a list of patient groups correlated with costs for the EOC. The result is that some patients would require fewer rehabilitation and medical services with lower weights while other higher intensity patients with higher medical and lower rehabilitation needs will result in higher weights. The goal is to assure that the patient groups are risk adjusted and accurately reflect the cost of service delivered and are relatively homogenous.

4. **Develop the Details of the Episode of Care: Definition and Payment Options**
   Base the CCHCGs on a per episode unit of payment, the EOC, using the CCH LOS and the subsequent 30 days in two phases. In phase one the inpatient CCH EOC would be analyzed to create a payment methodology that represents the inpatient stay. In the second phase, data would be collected on the inpatient CCH stay plus 30 days for the complete EOC. Payment options include a one-time bundled EOC payment. **AMRPA does not recommend** using a bid payment, in which the CCH would go at risk for outcomes initially, as this would result in many potential providers declining the opportunity to participate in the pilot.

5. **Calculate the Standard Payment Amount (Standard Conversion Factor)**
   Calculate and normalize the standard payment amount to determine the payment per episode.
6. **Provide for Adjusters and Special Payment Rules**
   Analyze the data to determine the adjustments needed for:

   a. Facility adjusters such as wages, LIP, rural, teaching, others.
   b. Special payment rules such as transfers, short stay cases, high-cost outliers, interrupted stays, and readmissions.
   c. Cost of specialized care not captured via a co-morbidity adjustment.

7. **Readmissions Payment Policies**
   If there is to be a readmission policy for cases readmitted from the CCH during the EOC to acute care, covered readmissions need to be defined as described above.

8. **Include Quality Measures**
   Quality measures would need to be chosen or designed similar to those that were adopted by CMS in the FY 2012 IPPS, LTCH and IRH/U rules. CMS should assess the applicability of measures used by SNFs, those included in the CARE tool, those proposed to NQF, and measures developed by the relevant professional associations including the AMRPA Quality Committee.

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

10. **Outcomes-Based Initiative**
    After initial implementation, revise the payment system to include bonuses for better functional outcomes and other improvements in patient care.

11. **Payment Outside the EOC**
    Analyze the data regarding the services, payments, and cost of CCH patients needing services after the EOC has expired and determine whether these will be paid based on the current payment models.

12. **Define the Term Common Management**
    Define the statutory term “common management.” Examine existing health care regulations for any precedent.

13. **Define Patient Care and Patient Safety Standards**
    The CCH must demonstrate the ability to meet patient care and patient safety standards. These must be defined.

13. **Estimate Savings**
    Streamlining the delivery system through the elimination of administrative requirements, such as the 25% rule for LTCHs, the 60% rule and three hour rule for IRH/Us, and the three day rule for SNFs, is expected to result in savings. Similarly, eliminating admissions and discharges internal to the CCH would result in savings since there would no longer be a need for separate medical records because the care is consolidated within the CCH. Improved coordination of care is likely
to reduce preventable readmissions to acute care as well as complications resulting from multiple admissions and discharges among the current silos.

**14. Coordination of Care**
The CCH would work directly with acute care hospitals to assure seamless and complete coordination care.
THE CONTINUING CARE HOSPITAL PILOT:
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Summary
The Continuing Care Hospital (CCH) Pilot Test was introduced in Sections 3023 and 10308 of the Patient Protection and Affordable Care Act of 2010 (PPACA) P.L. 111-148. The American Medical Rehabilitation Providers Association (AMRPA) strongly supported its inclusion in the health care reform legislation and is pleased that it was included in the final law.

This document reviews the need for the CCH concept, its development, and the requirements of the statute. It also puts forth principles, issues, and recommendations for how HHS/CMS might approach the pilot.

Introduction
The CCH represents both a new approach to the delivery of post-acute care and also financing reform for the medical rehabilitation services and complex medical services delivered by today’s inpatient rehabilitation hospitals and units (IRH/Us), hospital-based skilled nursing facilities (HSNFs) and long-term care hospitals (LTCHs). AMRPA (and its predecessor associations) has been developing this concept for years. It developed the monographs, Medical Rehabilitation: What It is and Where It Is in 1985; Charting the Course in 1995, and the white paper Post Acute Inpatient Levels of Care Proposal in 2005. In August 2007, AMRPA convened its Visioning and Future Planning Committee, which conceived the concept of the CCH. The CCH concept applies to all ages; children, adults and seniors, and is not limited to Medicare beneficiaries.

During the health care reform debate of 2009 and 2010, AMRPA proposed and promoted the creation of a CCH that would organize care around the patient instead of the provider. It would consolidate all three levels of inpatient post-acute care into a single enterprise with a single payment system, and single method for measuring quality and outcomes. It envisioned the CCH being implemented either as real (all care levels in a common building), or virtual (all levels operated as a single entity, but in two or more physically distinct locations). The CCH is intended to enhance the quality of care patients experience by eliminating boundaries among the current hospital-based post-acute care providers and implementing common quality standards, outcome measures, and accountability. It would result in reduced administrative costs to deliver complex medical and rehabilitation post-acute care, improve the cost benefit and cost effectiveness of post-acute services and enhance the quality of care received by patients. The final law embraced these concepts.

Background
Hospital based post-acute care providers, and particularly medical rehabilitation, are at a crossroads in their history in the United States. The medical rehabilitation field was developed in the first third of the 20th Century by visionary physicians who believed that there was more to health care than simply diagnosing and medically treating patients with serious permanent impairments. They believed that such patients could, with appropriate therapy, return to active and productive lives and thus contribute to their family, community, and the economic life of the nation. Over the years, physician-directed hospital-based multidisciplinary teams devoted to the principles of rehabilitation evolved into the field of medical rehabilitation as we know it today. The LTCH field evolved from treating TB and other chronic, medically complex diseases, during a similar period. Hospital-based skilled nursing facilities (HSNFs) also expanded starting with the onset of the DRGs in 1982 but retrenched with the start of the SNF PPS in 1998.

In March 2011, there were about 1,169 IRH/Us organized specifically to provide medical rehabilitation, over 15,700 skilled nursing facilities (SNFs) and over 430 LTCHs, which also provide medically complex care and some level of medical rehabilitation services to inpatients.

The post-acute sector grew with the advent of the inpatient PPS in 1983. With this growth has come confusion about how best to distinguish among the various post-acute facilities and the services they provide. Moreover, there is confusion about what care is clinically necessary, what is effective, what the best practices are, and what value is being received by patients and payers for that care. With increasing pressure on the funding for this care, and the growing numbers of facilities competing to offer these services, it is not surprising that many perceive that the current post-acute care market is chaotic, confusing, costly, and less than clinically optimal.

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

With the advent of the multiple PPSs established by the BBA, each provider type gained further identity, for better or worse. The “non-subsection (d)” hospitals, known as the TEFRA hospitals, are separately recognized as LTCH with the long-term care hospital prospective payment system (LTCH–PPS); psychiatric facilities with the inpatient psychiatric services PPS (IPS-PPS); and rehabilitation hospitals and units became inpatient rehabilitation facilities with the IRF-PPS; skilled nursing facilities have a skilled nursing facility PPS (SNF-PPS); and home health services were subject to several reductions in payment before the home health PPS (HH PPS) was implemented. Outpatient rehabilitation providers continue to be paid under the Medicare physician fee schedule. Physical, occupational and speech therapy services that are not hospital-based are currently subject to the financial limitations of the therapy cap.

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

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

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

The plethora of coverage criteria and definitional standards regarding either the types of patients or processes of care in each of these post-acute care venues has raised concerns in policy circles (such as MedPAC) that there are few accepted objective standards or criteria by which to assign individual patients to specific facility types. The MBPM provides certain criteria that are heatedly contested by providers. The American Academy of Physical Medicine and Rehabilitation (AAPM&R) has promulgated medical standards for determining the appropriateness of an IRH/U patient admission, but these are largely based on a consensus of expert opinion, and subject to differences of interpretation. MedPAC and CMS have discussed establishing patient criteria and provider standards for LTCHs, and quality measures have been implemented for SNFs through the Nursing Home Compare program however these measures do not lend themselves to the rehabilitation patient.

These factors point to a need to improve the post-acute care delivery system by focusing on patient, not provider, centered care. AMRPA proposed the creation of a CCH to strengthen the delivery system, focus on patient’s clinical needs first and improve the system’s cost benefit and cost effectiveness in the delivery of inpatient post-acute services.

**Statutory Mandate**
The Secretary of the Department of Health and Human Services (HHS) is required under Sections 3023 and Section 10308 of the Patient Protection and Affordable Care Act (ACA) to conduct a National Payment Program on Bundling and that “in conducting the pilot program the Secretary shall apply the provisions of the program so as to separately pilot test the continuing care hospital model.” See Appendix A. The CCH pilot test has several specific requirements:

1. It is not subject to the limitations on conditions listed for the national payment pilot on bundling;
2. The episode of care is specifically defined as the full period that a patient stays in the CCH plus the first 30 days following discharge from the CCH; and
3. A CCH is defined specifically as meaning an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in IRH/Us, LTCHs, and HSNFs. However, all the other provisions of the national payment pilot on bundling appear to be applicable to the CCH pilot test and must be considered in its design. Some may need to be modified. However, these include, in short hand form:

1. Various definitions;
2. Determination of a patient assessment instrument – it may be the same for both pilots. The CARE tool is given as an example in the statute;
3. Development of quality measures that are site neutral and developed in a manner consistent with measures developed and endorsed under section 1890 and 1890A that are applicable to all PAC settings;
4. The pilots are to start by 1/1/2013 and last for 5 years but may be extended; and
5. The participating entity is defined; however, it may need to be reconsidered for CCH purpose. It allows the entity to be comprised of providers and suppliers including a hospital, physician group, SNF or HHA;
6. The Secretary will assure that beneficiaries have an adequate choice of providers and suppliers under the pilot;
7. Payments may include “bundled payments and bids … for episodes of care”. The episode of care for this pilot is the CCH approach. Payment is not to exceed what would otherwise be spent for applicable beneficiaries;
8. Payment is to include payment for the services in question and other appropriate services such as care coordination, medication reconciliation, discharge planning, transitional care services and other patient-centered activities as deemed by the Secretary;
9. Bundled payments will be comprehensive and cover the costs of applicable services and other services furnished to an individual during an episode of care;
10. The Secretary will establish procedures to pay for PAC services after the last day of the episode of care;
11. The quality measures are specified and include:
   ‘‘(i) Functional status improvement.
   ‘‘(ii) Reducing rates of avoidable hospital readmissions.
   ‘‘(iii) Rates of discharge to the community.
   ‘‘(iv) Rates of admission to an emergency room after a hospitalization.
   ‘‘(v) Incidence of health care acquired infections.
   ‘‘(vi) Efficiency measures.
   ‘‘(viii) Measures of patient perception of care.
   ‘‘(ix) Other measures, including measures of patient outcomes, determined appropriate by the Secretary;” and
12. There will be an independent evaluation and interim and final reports.

**Principles**
Before analyzing the specific issues to be addressed in the CCH pilot, AMRPA recommends a number of guiding principles that must be met. These principles include:
1. **Patients**
   - The CCH pilot needs to be patient-centered\(^3\) 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 thereby assure 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 functional ability, and activity and participation in society, not just survival.
   - Conversely persons with medical problems associated with functional loss must have access to services that are focused on rehabilitative services to improve function and increase independence.
   - Any model of change must provide patients with an adequate choice of providers, suppliers and services.
   - The pilot should maximize outcomes and patient satisfaction.

2. **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.
   - Providers should be able to receive reasonable payment for delivering high quality care.
   - The pilot 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.

3. **Payers**
   - Cost-effective and cost-efficient care (in terms of cost and effectiveness) 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.

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\(^3\) Patient centered means the needs of the patient are the primary needs not those of institutions, professionals, payers or governmental programs.
4. 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.

5. Additional Criteria
- The pilot should adjust adequately for environmental and social factors consistent with the World Health Organization International Classification of Function.
- The CCH should encourage an economically rational organization of service capacity.
- Financial risk should be minimized.
- The pilot should be sufficiently robust to be replicable as a national program.
- The pilot should be budget neutral (e.g. Medicare expenditures would not exceed current payment for patients serviced by the three levels of services and other services stated in the statute which are encompassed by the CCH pilot.)

Continuing Care Hospital (CCH) Model: Overview
The CCH model is a significant change in the delivery system for post-acute care in order to resolve the problems and issues discussed above. The CCH would also provide or coordinate home health and outpatient rehabilitation services for patients who need them after discharge.

The CCH would operate under common management and hence could be an actual building (a hospital offering some or all three levels of service) or a virtual entity (an organization that provides under common management the three levels of service in more than one building or unit). A physician would make the admission decision regarding whether a patient should receive care within the CCH and determine which level of service the patient would need. Payment would be determined by the patient’s clinical and functional characteristics and the program resources needed to provide that care. Pilot test participants would be allowed to care for certain types of patients if they demonstrate the ability to provide care, as defined by law and regulation, meet specific patient care and patient safety standards, and demonstrate certain outcomes.

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

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

**Design Issues: Key Elements to Be Addressed in the CCH Pilot (As a Form of PAC Bundling)**

1. **Scope of Services to be Included in the CCH**
   The statute addresses the services provided during the CCH stay plus the 30 days post discharge. These services include those currently provided by IRH/Us, LTCHs, and HSNFs. Hence, they would include specialized physician and nursing care, extensive therapy services, and any other currently covered services. There may be a need to also include durable medical equipment, orthotics, and prosthetics unless they would continue to be paid on a different schedule based on the payment recommendations. The statute also states that payment will include other services such as care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities as determined by the Secretary.

   In addition laboratory work, outpatient services, home health services, emergency services and other diagnostic services currently recognized in the IRF, MS-DRG LTCH and SNF PPSs would need to be accounted for and included.

   **AMRPA Recommends**
   AMRPA recommends that the scope of services included in the CCH pilot cover all the services mentioned above, including physician services. AMRPA recommends that emergency room services and certain high cost services, such as dialysis, not be included.

2. **Duration of the Episode/ Definition of the Episode**
   The duration of the episode of care (EOC) is also stated in the statute as the CCH stay plus the 30 days of service post discharge from the CCH. However numerous issues are involved in defining the stated EOC. The ASPE study on “Post Acute Care Episodes of Care” provides some guidelines and considerations in deciding where the EOC service and cost bundle ends, which it describes as either a) variable or b) fixed which includes any claims starting during the episode.
The divide between the CCH and long-term care is somewhat discretionary and needs to be monitored to assure no stinting of care occurs by shifting patients to long-term non-SNF [non-Medicare] care earlier than their clinical status warrants.

Another factor to consider is to include when a new EOC starts. For example, if a patient is readmitted to the acute hospital, and then returns to the CCH, then does a second EOC start? Also if a patient is discharged from the CCH and during the post 30 day period is readmitted to the acute care hospital and then readmitted to the CCH, or then returns to the setting from which they were admitted such as home with outpatient services, the same question remains.

Part of this determination rests in the definition of the original EOC, be it a fixed or variable approach and part of it may be the length of time from when the patient returns to the acute hospital and returns to the CCH. Hence, clear entry and exit points would need to be defined. Several scenarios are likely:

a. the patient leaves the CCH for an unrelated condition and comes back for treatment for the original condition.

b. the patient leaves the CCH for an unrelated condition and returns for treatment of a condition different from the first admission.

c. the patient leaves the CCH for an unrelated condition and returns for treatment of the new condition and the original condition.

d. if the patient is discharged from the CCH to home health, community SNF, outpatient care, home or hospice care, is readmitted to the acute care hospital within the 30 days post the CCH discharge, and then returns to either the CCH, or the CCH discharge setting, would there be a new EOC and payment?

One approach would be to state that if the patient leaves the CCH and returns to the same or a different CCH, it would be a new EOC whether the treatment is for the same condition or not, and whether there needs to be any coordination with the acute readmission policy and any payment incentives. For example, a wound patient is admitted and at the time it is known that they will be going back to the acute hospital for surgery and remain for 1-3 days. This move would not start a new EOC and payment.

However, a patient who is admitted for a stroke, falls and fractures a femur, returns to acute care for surgery and does not return to the CCH for 4 or more days due to medical complications would start a new EOC and payment subject to coordinating with the acute care readmissions policy.

In the instance where the patient is discharged by the CCH to an outpatient setting (home, home health, outpatient services, community-based SNF, hospice) and then is readmitted to the acute care hospital within the 30 day post CCH discharge, the CCH could receive a per diem payment if the period of time was lower than a computed average LOS, and the readmission was preventable, similar to the transfer policy under the IRF PPS.

AMRPA Recommends
AMRPA recommends that CMS work with AMRPA in defining the episode and the two options for fixed and variable length episodes as discussed in the referenced RTI study. It will
be the responsibility of the contractor to provide further recommendations on the definition of the episode of care to include patient entry (admission to the CCH), and transfer and exit points.

**AMRPA recommends** that if there is an interruption of care for any reason of 4 or more days, and the patient returns to a CCH or CCH discharge setting to treat a new or same condition, it will be treated as a new EOC and payment, subject to the readmissions policy.

**AMRPA recommends** that the CCH pilot not be limited to a number of conditions but include all those that are treated in the three levels of services included in the CCH.

3. **Coordination with Existing Medicare Benefits Package**

Another issue is how to treat Medicare beneficiaries who have exhausted their benefits, how the days are currently accounted, and payment. The current discharge or per diem “episodes” are aligned with the Medicare benefit package regarding days of care, deductibles and co-insurance. A key issue is assuring that beneficiaries don’t bear unintended additional costs with respect to co-insurance and co-payments. One approach is to redesign/ reexamine the Medicare benefit package and assure that the episode of care takes into account current Medicare Part A benefits, Medigap policies as secondary payers and the shift from Medicare to Medicaid.

Hence, as with the national bundling pilot, the CCH raises questions concerning how payment may operate and if it will change the level of Medicare benefits available to beneficiaries and their financial liability. The CCH may also affect beneficiary co-insurance and deductible obligations, patient spend-down as well as Medigap, Medicaid and other secondary Medicare payer obligations.

These differences in coverage and beneficiary liability need to be considered and aligned in the pilot. Various approaches include:

a. Provide Medicare beneficiaries who participate in a CCH payment pilot program with a waiver of deductible obligations for both hospital and SNF services particularly in the instances where the stay may exceed current hospital stay limits. [NOTE: under the current ACE program the patient’s costs are estimated for each episode and then paid directly to the patient’s supplemental carrier.]

b. Issue exhaustion of benefit notices at the same time as would be the case under the fee for service payment system to accurately mark the time of secondary payer and Medicaid program financial liability

c. Install a budget neutrality requirement for Medigap, other secondary payers and Medicaid programs which ensures that bundled payments which derive from the Medicare Part A trust fund are not substituted for third party insurance and public assistance liability/payments which would have occurred had bundled payments not been made.

d. Provide that Medicare secondary payments and Medicaid payments are made to providers who participated in the CCH program at the same time and in the same amount as would have occurred with the absence of the a bundle payment pilot project. These would be
additional regulations to be waived or altered during the bundle or new statutory authority may be required to institute these recommendations.

4. Admission Criteria

Any patient who currently needs what are characterized as LTCH, IRH/U or HSNF medical and rehabilitation services would be an appropriate patient for the CCH. Admission to the CCH would depend on the status of the patient at the moment they are considered for discharge from the acute hospital or referral from the community. A preadmission screening would be conducted to determine if they meet the factors included in the admission criteria.

The factors included in admission criteria are:

a. The patient’s immediate medical needs are resolved; the likelihood of rapid or daily medical stability change is low.

b. Their immediate medical and surgical procedures are completed.

c. They exhibit continued medical and functional problems which prevent them from being safe in a community environment.

d. There is an expectation that patients will benefit from the multidisciplinary program of care and resources as opposed to single service care in an outpatient or home health setting.

e. The patient requires physician supervision by physicians with medical and/ or rehabilitation experience in treating complex medical and rehabilitation patients.

f. The patient requires nursing services and expertise that vary in intensity and treatment, including rehabilitation nursing which incorporates reinforcing the therapeutic exercise and functional skills and education provided by therapists.

g. The patient needs interdisciplinary therapy services delivered in a coordinated manner to meet functional goals.

h. The patient is expected to benefit from the medical and/ or rehabilitation services in a predictable period of time. Such benefit may include improved medical status and improvement in, maintenance of, or prevention of deterioration of functional capacity.

i. The patient is expected to be discharged to a less intense setting which may include the community, including assisted living or community-based nursing home, with or without continued medical or rehabilitation services (e.g. home health, hospice or outpatient services).

5. Common Patient Assessment Instrument/ Method

A common patient assessment instrument may be used to provide data to include in making admission and continued stay decisions. Such an instrument should not be a sole decision support tool nor used as the predictive model for admission or discharge. Such decisions must be made in conjunction with the observations and expertise of physicians with experience in treating patients with complex medical and medical rehabilitation needs, nurses and therapists.

Any such patient assessment instrument needs to meet several criteria. These include:

a. It is administratively feasible to implement and not too burdensome, e.g. does not exceed 45 minutes to complete

b. It utilizes computer adapted testing methodology.
c. It covers all domains related to complex medical and medical rehabilitation care.
d. It captures patient characteristics and reflects their resource use.
e. It provides for evaluation for patients’ long-term outcomes of treatment.
f. It has predictive validity and reliability.
g. It has minimum floor and ceiling effects which are well identified when utilized on the
   patient populations in question. Patients who might be affected by these effects can
generally be identified and allowance made for their treatment and admission. In those
instances alternative tools may be utilized.
h. It utilizes the ICD-10-CM codes.
i. In addition to medical and functional information and items, it incorporates the
   International Classification of Function (ICF) components of Activity and Participation

At a minimum a CCH patient assessment instrument must include the following elements:
   a. Administrative information;
   b. Medical information including co morbidities;
   c. Functional information including motor, self care and mobility and cognitive function;
   d. Environmental factors;
   e. Social factors including activity limitations and participation restrictions using the ICF
      conceptual framework, which include sensory experiences, basic learning, applying
      knowledge, general tasks and demands, domestic life, interpersonal interactions and
      relationships, community, social and civic life among others;
   f. Resource consumption;
   g. Long-term follow up for patients;
   h. Quality measures for process and outcomes measurement; and
   i. Other

Current tools (IRF PAI, MDS 3.0, LTCH MS-DRGs and UB forms) to collect common data
have been proven to be incompatible in content. The statute references the CARE tool as a
possible patient assessment instrument for determining the site of post-acute care. It is a
cross-site instrument which has collected data from all the sites of care in question which was
done as part of the post-acute care payment reform demonstration (PAC PRD) project. The
various versions of the CARE tool (for inpatient and outpatient settings) need to be revised as
needed based on the current experience from the PAC PRD and to meet the criteria outlined
above. The current draft of the CARE tool is on the project website and is from December,
2009 (www.pacdemo.rti.org). The CARE tool is lengthy. However current research into the
use of computer adapted testing (CAT) which Alan Jette, Ph.D. has discussed may relieve
some of the burden. Other tools or other items may be examined for inclusion such as the
AM –PAC which includes functional measures recommended by the WHO International
Classification of Function. We have also had a work group looking at examples of how the
tool could be amended to address some of the above principles, particularly incorporation of
the ICF concepts, measurement, items and nomenclature. Using these new tools or a revised
version would remove recognized problems with different existing tools. See Appendix D
for an example of such amendments.
AMRPA Recommends

CMS:

a. Consider utilizing a revised CARE tool amended to include the criteria mentioned above.

b. CMS examine Attachment D as an example of one way to address changes to the CARE tool.

c. If data cannot be collected using the ICD-10-CM then assure that the codes collected can be adequately cross walked to the ICD-10 via the GEMS. The ICD-10 would provide a much richer medical status picture of the patients.

6. The CCH as the Accountable Entity: Provider Requirements

a. Statutory Requirements

The CCH must meet certain criteria for participation in the pilot. Those included in the statute:

- Meets patient care standards
- Meets patient safety standards
- Is operated under common management
- Is capable of reporting on the specified quality measures
- Provides the medical and rehabilitation services currently provided by LTCHS, IRH/Us, and HSNFs

In addition, the CCH will need to demonstrate the following capabilities be it via an actual or virtual CCH for purposes of the pilot. They focus on the physical and service attributes, i.e. provider characteristics. It must have the following components and abilities:

(i) Licensure
   (A) Be licensed as a hospital

(ii) Program Component
   (A) Comprehensive medical rehabilitation and medically complex programs are organized as physician led multidisciplinary teams that work to achieve goals that are directed towards improving a patient’s health status and functional abilities.
   (B) Patients are admitted who have significant functional limitations and/or medical problems that are expected to benefit over a period of time using the varying intensity of services and programs available through the CCH.
   (C) There is a preadmission screening procedure, overseen by a physician, to determine if a patient is expected to benefit from an intensive inpatient program or assessment.
   (D) Multidisciplinary team conferences, led by the physician, are held at least weekly. At those conferences, initial patient assessments, current status, goals, and progress towards goals and discharge plans are shared.
   (E) Comprehensive medical rehabilitation and medically complex programs are organized as physician led multidisciplinary teams that work to achieve goals that are directed towards improving a patient’s health status and functional abilities.
(F) The CCH plans the patient care, treatment and services based on needs identified by the patient’s assessment, reassessment and results of diagnostic testing. The plan of care is also based on the patient’s goals, timeframes, services, and progress.

(G) Patients are admitted who have significant functional limitations and/or medical problems that are determined to be likely to benefit over a period of time using the varying intensity of services and programs available through the CCH.

(H) In general, the discharge goal for the patient is to the least restrictive environment and is expected to be a less restrictive living situation than would be possible without the intervention of rehabilitation.

(I) The CCH would also:
   (I) Provide physician oversight and availability
   (II) Meet quality and safety standards
   (III) Meet specific outcomes
   (IV) Provide case management
   (V) Manage transitions along the continuum
   (VI) Coordinate medication management
   (VII) Provide or has available the full range of diagnostic testing (as appropriate)
   (VIII) Provides the necessary education to the patient and caregivers to promote successful post discharge status.

(iii) Physical Space
   (A) The CCH program has space that is safe, contiguous, and accessible for people with functional and severe medical limitations. The space will be sufficient for the numbers and kinds of patients to be treated, including:
      (I) Gym and other dedicated space with specialized equipment for delivery of therapy services and treatment of functional loss.
      (II) Dedicated space for teaching daily living activities, including a bedroom, bath, kitchen and space for mobility training.
      (III) Inpatient beds aggregated in a designated and distinct space if part of an acute care hospital.
      (IV) Dining, storage, administrative including human resources, linen, admissions, receiving, clinical, environmental and engineering services.

(iv) Professional Staffing
   (A) Medical Director
      (I) Provides services to the hospital or unit and its inpatients on a full-time basis at least 40 hours/week
      (II) Is a doctor of medicine or osteopathy;
      (III) Is licensed under State law to practice medicine or surgery; and
      (IV) Has had, after completing a one year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services or inpatients requiring medically complex services.
(B) Programs are provided by a multidisciplinary team and the team will be comprised at minimum of the following:

(I) Constant availability of physicians with special training or experience in the field of rehabilitation medicine, frequently and directly involved in medically necessary patient care, at least 3 days per week.

(II) Availability of physician specialists as part of an organized medical staff.

(III) Constant on-site availability of registered nurses with specialized training or experience in rehabilitation, treatment of wound care, ventilator dependent patients and other complex medical and rehabilitation conditions.

(IV) Availability of adequate physical therapists (PT), occupational therapists (OT), speech language pathologists (SLP), psychologists, (including neuropsychologists) social workers, case managers, and recreational therapists, respiratory therapists, licensed and registered professionals under the direction of a physician so that each patient receives the intensity of services needed for their care. Therapy services are provided at the direction of a physician in the complement required by the patient to achieve team established goals.

(V) Availability of the services of social workers, case managers, and others provided under the direction of a physician.

(VI) Availability of laboratory, radiology, and pharmacy services.

(v) Quality Improvement

(A) Outcome and process measures are used for quality improvement of patient care processes including indicators such as those required under the pilot.

(B) Active input at the program level is provided by consumers and community members, and utilized by the CCH to revise and adapt its programs and services.

(vi) Services provided should have certain attributes including maximizing innovation and be based upon the best available clinical evidence.

Services should be patient-centered and organized to meet the needs of patients. Care must provide access to medical rehabilitation and medically complex services that are focused on prevention of further medical complications and intended to improve or prevent deterioration of health, outcomes, functional ability and activity in society. In addition, services should maximize innovation and be based upon the best available clinical evidence. The services should minimally include:

- Medical, nursing, PT, OT, ST, therapeutic recreation, dietary, nutritional services, psychology (including neuropsychology), dental, infection control, environmental services, plant, medical records, transport (internal and external – ambulance), pharmacy, durable
medical equipment, prosthetics and orthotics, laboratory, radiology, case management, respiratory therapy, social services, emergency services, and other diagnostic services as currently provided in an IRF, LTCH, SNF, and outpatient settings or a home health service.

(vii) Other Attributes
(A) Demonstrate dedication of hospital, physician, nurse, therapists’ etc. time to the pilot.
(B) Be able to deliver, or contract for, the entire bundle of services to be rendered.
(C) Have clinical pathways and effective discharge planning capacities and case management within the CCH.
(D) Be able to manage transitions or handoffs from one service to another when necessary.
(E) Have interoperable HIT and decision support systems.
(F) Be able to monitor patients’ clinical status.
(G) Coordinate medication management and reconciliation as patients progress from the acute setting to the CCH, and within services of the CCH.
(H) Assure the scope of services is commensurate with the intensity and complexity of services needed.
(I) Physicians will make admission and transition decisions, determine if a patient should be receiving care within the CCH and determine which level of service the patient needs within the CCH at admission and during their stay.
(J) Have the ability to track quality indicators and patient outcomes across the array of services.
(K) Be able to manage medical complications and go at risk for readmissions and medically complicated patients.
(L) Be able to coordinate with other community services to help foster the patient’s independence.
(M) Have the necessary financial systems to administer payment across multiple entities.
(N) Be able to tolerate financial risk and understand its own risk exposure.
(O) Meet minimum volume standards for overall patient care, specific types of patient care and care for the conditions specified by the Secretary.
(P) Meet specific patient care and patient safety standards.
(Q) Have a method of classifying patients by the complexity of their needs.
(R) Be capable of networking with multiple other providers to provide all CCH services and post CCH discharge services.
(S) Have an organized medical staff.

(viii) Accreditation
Most entities would continue to keep their current accreditations in place during the pilot, including program specific accreditations. For example, a current IRH/U may have accreditation for its TBI and spinal cord programs.
b. Patient Clinical Criteria
Patients are described with the same parameters as are used for the acute hospital and followed to the CCH.

(i) Patients are characterized by the magnitude of intensity and sophistication of the medical and nursing care required.
(ii) Patients are characterized by the degree of coordination of the multidisciplinary rehabilitation and medical teams required over the course of their care.
(iii) Patients are characterized by their level of volatility and change and their needs over stated periods of time.
(iv) Medical and therapeutic supervision is required in order to change the individual plan of care as needed such that if there is rapid, sudden, or unexpected change the CCH is capable of recognizing same and adapting to it.
(v) The patient benefits from coordinated multidisciplinary care for their medical, therapy and nursing needs during the most intense part of their care in the CCH and from less intense individual services during the less intense part of their care, e.g. toward the end of the episode of care.

c. Patient Safety Standards
Patient safety is the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum. The statute requires that the CCH meet patient care and patient safety standards. Some standards are included in the Conditions of Participation for Hospitals which it is presumed all CCHs would meet since the initial intensity of care is at the hospital level based on the statute. For example, would the patient care standards include any of the current IRH/U patient coverage criteria processes without the specificity since the types of patients would vary? Sources to investigate further include JCAHO, AHRQ and a closer examination of the Hospital Conditions of Participation.

These patient safety standards might include:

(i) Emergency codes and emergency operations plan
(ii) Life safety codes;
(iii) Infection protocols,
(iv) Storage of drugs and biological
(v) Criteria for admission, continuing care and discharge
(vi) Specific care requirements for ventilator patients
(vii) Medication use
(viii) Standards regarding transfusions, restraints, and seclusion
(ix) Staffing and staff competence
(x) Fire safety and overall life safety
(xi) Security
(xii) Hazardous waste

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The Medicare Conditions of Participation include as patients rights the following. A CCH should be required to be certified by Medicare as a hospital and would be subject to those requirements.

(i) Notice of rights  
(ii) Exercise of rights  
(iii) Privacy and safety: “the patient has a right to receive care in a safe setting”  
(iv) Confidentiality of patient records  
(v) Restraint for acute medical and surgical care (or right to be free there from)  
(vi) Seclusion and restraint for behavior management

JCAHO provides for the following with respect to Patient Care standards for hospitals and may be adopted for the CCH. CMS may also want to examine CARF standards for medical rehabilitation programs:

(i) Medication management: (Medication planning, selection & procurement, storage, ordering & transcribing, administration, monitoring & evaluation)  
(ii) Patient Safety Goals: (Improve accuracy of patient identification, improve effectiveness of communication among care givers, improve the safety of using medications, reduce the risk of healthcare associated infections, accurately and completely reconcile medications across the continuum, reduce the risk of patient harm from falls, prevent healthcare associated pressure ulcers, identify safety risk for suicide)  
(iii) Provision of care, Treatment and Services: (Plan – admission, assessment & planning; implement – providing, coordinating care & patient education; special consideration – special procedures, restraints & seclusion; discharge & transfer – planning & continuum of care; blood safety)  
(iv) Performance Improvement: (Data collection, data analysis, performance improvement, staffing effectiveness for patient acuity and competency)  
(v) Rights & Responsibilities: (Patient rights and patient responsibilities)  
(vi) Policies and Procedures: (Interdepartmental/service line transfers, staff competencies, administrative: visiting hours, objectives (mission & vision), lines of authority, abuse, confidentiality, employee recruitment, transfer agreements, written agreement for contracted services, advance directives, patient rights, patient education, admission and discharge, medical staff orders (history and physical, etc.), informed consent, infection control, emergency care, staffing for acuity, education and orientation of patient.)

7. Common Management  
Common management may be accomplished through a partnership, professional corporation, limited liability company, joint venture, foundation, or nonprofit corporation. The managing
head, be it employee, director or however designated, may be a general manager, administrator, director or another individual that exercises operational or managerial control.

Overall duties will include but not be limited to: planning, organizing, staffing, leadership, budgeting (single billing number), authority to contract and negotiate, common medical record, organized medical staff. In addition, no physical component of the CCH could be more than 35 miles from one other component. This approach is intended to mirror CMS’ provider-based rule.

Common management will include a designated separate governing body, organized medical staff, a chief executive officer, and the form would be further defined by the CCH’s bylaws and rules and regulations.

8. Meet Quality and Outcome Measures
In the CCH, as in the national bundling pilot, it is critical that there be reporting of quality data and measurement of quality performance on these quality measures. In addition, if such measures become performance measurements, they should assure that patients are receiving the level of services and care their conditions require and that there is no stinting on care.

At a minimum, such measures should be relevant to the population of patients, cover a broad scope of medical status and functional ability, be reliable and valid as measures, and be operationally feasible to use.

The statute is clear that the Secretary is to establish certain quality measures for care that the CCH is to meet. The statute requires the pilot(s) to include developing the following measures:
   a. functional status improvement;
   b. reducing rates of avoidable hospital readmissions;
   c. rates of discharge to the community
   d. rates of admission to an ER after hospitalization;
   e. incidence of acquired infections
   f. efficiency measures
   g. measures of patient-centeredness of care
   h. measures of patient perception of care
   i. Other measures including measures of patient outcomes determined appropriate by the Secretary
   j. Long-term measures of integration into former life roles and society.

These measures must be risk adjusted.

In addition, the measures selected would also need to include those adopted by CMS for reporting proposes pursuant to the ACA and currently available such as mortality. As the ICD-10 coding system is adopted, the parallel adoption of the World Health Organization’s ICF should also be pursued. This would provide data to monitor the CCH outcomes in the domains of Activity and Participation, as well as disease and disability.
Despite the desirability of using measures of functional improvement as an important assessment factor, there needs to be clear recognition that the current functional measures are not sensitive at both the most severely impaired level and at the highest level of ability. They also do not capture critically important benefits in the quality of life domain for certain extreme patient conditions, such as patients with tetraplegia or brain injury, among others. In these types of cases, other measures of benefit will need to be developed and adopted. In addition the cognitive items on the current IRF PAI are not particularly strong such that AMRPA recommends that only motor measures be used for the pilot if the IRF PAI is used as a data assessment tool or basis for quality measures.

Once the data are collected over a period of years, the use of performance measures would allow development of incentive payment methods to reward those institutions that constantly achieve better risk-adjusted medical and functional outcomes, which probably require longer lengths of stay. Such performance incentives can be developed in a budget neutral manner.

Development of performance measures would be coordinated with those entities that have already been exploring the issue such as CMS, the AAPM&R Clinical Quality Improvement Committee, CARF, the Joint Commission, NQF, the AMRPA Quality Committee, and the IOM.

AMRPA suggests the quality measures included in Appendix B.

9. Payment Methodology
The CCH payment methodology is presumed to be a bundled payment for the episode of care. The unit of payment is the EOC in contrast to a per discharge or per diem approach. The Secretary is to develop the payment method(s) which may include bundled payment or bid payment. The law says that payment is not to exceed the current program expenditures for the bundle.

10. Payment Considerations
   a. General Discussion and Treatment of Beneficiary Costs
      The CCH model is intended to create incentives to treat a wide range of patients with special care needs. Payment should include a standard payment amount per patient episode of care including risk adjustment to acknowledge patient differences and variability in cost. It is critical in designing the payment amounts that all Medicare payments, cost and resources used related to the episode of care be included for purposes of calculation for each episode. It is presumed the EOC payments are to include Part B payments, other than physician services. The Part B payments for all outpatient, skilled nursing facility and home health services will need to be accounted for as well as the Part A payments. Medicare payments may be determined via claims, cost reports, and cost resource utilization information. In addition, because of the structure of the EOC, the accounting for payment/ costs should also include those costs currently borne by the patients, such as SNF co-pays, any hospital deductibles, etc. One approach to beneficiary costs would be to devise some form of beneficiary shared savings as is taken by the ACE program as a way to keep the providers whole with respect to payment.
Under the ACE program, the program savings are shared with the beneficiary. The following is taken from the CMS ACE descriptive documents:

**“Savings Shared with Medicare Patient** - This demonstration provides an opportunity for Medicare to share savings achieved through the demonstration with beneficiaries who, based on quality and cost, choose to receive care from participating demonstration providers. However, beneficiaries will still be able to choose a hospital that best meets their needs and will not be restricted by this demonstration. Medicare will share 50 percent of the savings it gains under the demonstration with the Medicare beneficiary up to a maximum of the annual Part B premium, currently $1,157. The exact amount of the shared savings payment will vary by site and procedure. Medicare will send the shared savings payment directly to qualified beneficiaries approximately 90 days after they are discharged from the hospital. These payments are subject to Federal, state and other income taxes. (Those Medicare beneficiaries who are receiving Medicaid benefits are not eligible to receive shared savings payments.)"

The CCH could also be paid a staggered per diem if the patient leaves early in the EOC and/or leaves for a number of days (planned or unplanned) and is readmitted. A staggered per diem would acknowledge that the highest costs of care occur during the front part of a patient’s stay and the lower costs toward the end of the stay and the EOC. These would have to be calculated for each EOC group as they have different cost profiles.

As noted, the cost of care for this patient population has an extensive range, and, among similar diagnostic groups, is highly variable, which may affect the ability to move immediately to a complete bundled approach. See below.

**b. Special Payment Adjustments**

**AMRPA recommends** that the CCH pilot include special payment policies and adjustments including:

(i) High cost outliers

(ii) Carve outs for costs not related to the conditions for which EOC treatment is given, DME and other treatments (e.g. dialysis, non related hospital readmissions)

(iii) The demonstration project be implemented in two phases due to the lack of data regarding the cost of a CCH stay that includes multiple levels of post-acute care. The first phase would establish data on the inpatient stay. The second phase would include the complete EOC, e.g. the inpatient stay plus 30 days.

(i) During Phase II CMS should collect data and CCH utilization, and payments to predicted utilization from comparable patients treated in conventional silos.

**c. Readmissions**

Additionally the pilot should address patients discharged from the CCH who are readmitted to the acute hospital within the 30 days post discharge from the CCH. Any payment incentive, i.e. reduction in EOC payment, should be excluded if the condition was unavoidable or unrelated to the original condition requiring admission to the CCH. If the readmission was related to the original condition, then the EOC payment may be reduced by the same percentage by which an acute care readmission would be reduced. This is the
concept of “shared pain”. Hence the CCH would share the risk of the readmission with the acute care hospital.

AMRPA Recommends
(i) For planned readmissions to acute care, there would be no reduction in payment to either the CCH or acute care hospital. The cost of a planned readmission would not be included in the EOC payment to the CCH and would be a separate payment to the acute care hospital.

(ii) Payment to the CCH would not be reduced for an unavoidable or unrelated readmission to an acute care hospital within 30 days of the discharge from the CCH or from the acute care hospital. For a discussion of one approach to defining unavoidable and preventable see “Identifying Potentially Preventable Readmissions”, Goldfield, et al, Health Care Financing Review, Fall, 2008, vol. 30., no. 1, pg. 75 and “Redesigning the Medicare Inpatient PPS to Reduce Payments to Hospitals with High Readmission Rates”, Averill et al, Health Care Financing Review, summer 2009, vol. 30, no.4, pg. 1. These articles set forth an approach to defining potentially preventable readmissions (PPR). CMS has also acknowledged the need to address such readmissions in the FY 2012 IPPS-LTCH rule.

In summary, in that literature a readmission is considered to be clinically related to a prior admission and potentially preventable if there was a reasonable expectation that it could have been prevented by one or more of the following: (1) the provision of quality care in the initial hospitalization, (2) adequate discharge planning, (3) adequate post discharge follow up, or (4) improved coordination between inpatient and outpatient health care teams. A specific time interval would be defined. Various exclusion criteria are also identified and include (1) various types of cancer, multiple trauma, burns, and certain chronic conditions such as cystic fibrosis; (2) neonatal and OB admission and admissions for eye care which have unique follow up care requirements’ and (3) admission with a discharge status of “left against medical advice.” Also excluded are admissions with a discharge status of “transferred to another acute care hospital.”

Similar criteria can be discussed for readmissions to the CCH. If the acute readmission is related to the original condition requiring admission to the CCH and may have been avoided, e.g. PPR, then there would be a reduction in the CCH payment.

(iii) The terms “unavoidable,” “unplanned,” or “unrelated,” “avoidable,” as well as “related” would need to be defined as part of the quality measures to be involved with the pilot.

d. Physician Services
The statutory language for the CCH appears equivocal about whether or not physician services are to be included in the bundle. The law requires that the payment methodology
for the national bundling pilot program, and possibly the CCH program, is to include applicable services, which include physicians’ services.

**AMRPA Recommends**
The CCH pilot should include primary physician services but exclude consulting physician services.

e. **Provider Adjustment Factors**
Certain cost variations that are not within providers’ control should also be accommodated for in the payment system. They may be a function of governmental (state, local, or federal) requirements, geography or unique system delivery factors and need to be recognized. These may include:
(i) Wage adjustment
(ii) Teaching adjustment
(iii) Rural area location
(iv) Low income patient load

**AMRPA recommends** that the payment methodology include adjustments for the factors listed above.

f. **Payment for Services That Extend Beyond the EOC**
The pilot would also have to address treatment of, and payment for, services provided outside of the CCH episode of care. The current payment systems would remain in place for people served outside the EOC timeframe who might need acute care that does not fall within the readmissions framework, including in community-based SNF, nursing home, assisted living services, home health, hospice, or outpatient services.

**AMRPA Recommends**
For patient services required beyond the definition of the EOC CMS should continue to pay for them based on the current payment systems.

g. **Case Mix Adjustment**
As noted more below, the CCH outcomes measures and payment must be case mix adjusted for each EOC’s costs. Otherwise all payment is unfair and the incentives created can be disastrous in promoting high quality patient care and injurious to patients, particularly highly complex patients. Such adjustment factors include function, medical severity, age, gender, as well as social factors such as social support at home or in the community, socioeconomic status, and language among others. Early work on the CARE tool, as well as some of the RTI ASPE studies, mention these factors as well. Another discussion of the need for risk adjustment can be found in “Need for Risk Adjustment in Adapting Episode Grouping Software to Medicare Data” Macurdy, et al. Health Care Financing Review, Summer 2009, vol. 30. No. 4, pg. 33.

**AMRPA Recommends**
All payment categories should be risk adjusted.
h. Quality Incentive Payments
The pilot should provide for quality incentive payments, if possible, given the nature of the data. These payments would include incentives for reporting the quality data during the pilot. It will be more difficult to have incentive payments for performance based on the quality measure when there has not been a common data collection tool across levels of service from which to establish benchmarks and then payment incentives. This approach assumes a per provider approach to payment for quality incentives. Once a baseline of quality data is collected then benchmarks can be established from which to develop the incentive payments.

**AMRPA recommends** that there be incentives for quality measurement reporting during the pilot and then when the pilot becomes a program, that data be collected for 2-3 years from which to establish benchmarks for developing incentives.

**AMRPA recommends** that during the time of the pilot participants report data for the quality measures outlined plus others determined by the Secretary. AMRPA also recommends that the quality incentives take the form of bonuses. Also AMRPA is concerned that reporting on data may not be adequate to assure quality of care is delivered.

11. **EOC Patient Classification System**
In order to operate, the ideal CCH model requires a patient classification system that accounts for patient characteristics and resource utilization for the period of the EOC. A traditional patient classification system then could be used for purposes of outcomes measurement as well as payment. For example, in the IRF PPS, the IRF PAI is used to collect data about patients and categorize them into case mix groups (CMGs). CMGs are based on several factors: age, motor and cognitive status on admission, and co-morbidities. They are then tied, in this case, with payment information (Medicare claims and cost reports) to create CMG weights using the hospital specific relative value weights methodology. Payment is per case per discharge. A similar pattern utilizing diagnostic information only is used for the MS-DRGs and the LTCH MS-DRGs. The SNF PPS utilizes a different patient assessment instrument (MDS 3.0) to gather information about the patient and expected treatment times. The payment system is based on resource utilization vs. payment information and is paid on a per diem vs. per discharge payment unit.

At a minimum, the data must include attributes such as diagnosis, motor and cognitive function on admission, motor and cognitive function on discharge, severity, age, sex, race, co-morbidities, LOS, medical information available on admission and discharge, status prior to acute care admission, home status, SES, infection rates and impairments, and outcomes expectations. In addition, it needs to account for discharge destinations, death rates, planned, unplanned (preventable, avoidable) readmission rates, costs, payments and resources used. The objective would be to gather and compare medical and functional status and other characteristics among the patients currently being served in various settings. This work, at least conceptually, is part of the focus of the PAC PRD demonstration program currently underway by CMS.

From these data, the next step is to create new patient groups reflecting the attributes mentioned above and which must be risk adjusted. The conceptual and methodological
approach undertaken by the RAND Corporation in the creation of the Case Mix Groups ultimately used in the Inpatient Rehabilitation Facilities Prospective Payment System (IRF PPS) is a classic prospective payment system and a possible to model to follow.

However, while a patient classification system for the EOC may be the ideal, the variability in this patient population suggests it would take several years to develop a viable system to predict resources and cost. Hence, during the pilot CMS may want to continue payment based on the FFS models with a shared savings incentive and anticipate moving to payment based on bundled payment perhaps by condition by EOC and risk adjusted over the time of the pilot.

12. List of Medical and Rehabilitation Services
The law refers to the medical and rehabilitation services provided by specified entities- IRH/Us, LTCHs and HSNFs are included in the CCH EOC.

13. Statutes and Regulations
In conducting the CCH pilot (as well as the national bundling pilot) CMS has the authority to waive Medicare and other regulations and parts of the statute. These need to be examined and delineated for these purposes. For example, the IRF PPS would be anticipated to be waived at some point in the pilot, as the CCH would be paid on per patient episode of care vs. a CMG on a per discharge basis. Additional exclusions critical to the success of the pilot project include: 60% rule, 3 hour rule, 25 day LOS rule, etc.

14. Evaluation Criteria for the Pilot
a. It needs to be nationally representative of the types of services/ providers encompassed by the statute with respect to inpatient rehabilitation hospitals and units, LTCHs, LTCHs within hospitals and HSNFs with respect to size, geography and possibly ownership.
b. The sample size of patients must also be nationally representative of the types of case, payment and resources used in all three levels of care.
c. It must cover both the real and virtual concepts.
d. Other criteria might include:
   (i) Performance on quality measures
   (ii) Performance on efficiency measures
   (iii) Standards/ measures pertaining to accessibility to care
   (iv) Standards/ measures of patient satisfaction
   (v) Others?

15. Other Considerations
a. Pay providers to participate.
b. Common electronic platform or platforms that can communicate across former sites of care are necessary.
c. Include a hold harmless clause in the provider participation agreements for the pilot.

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

**Steps Required to Implement the CCH**

The issues listed above are intended to start the discussion regarding the factors to be considered in designing a CCH pilot model. The steps outlined below are those that are taken to support or investigate the various design issues.

1. **Data Base Design**
   a. **Services**
      Define the medical and rehabilitation services provided by IRH/Us, LTCHs, and HSNFs. Measure all the medical and rehabilitation services received by patients in IRH/Us, HSNFs and LTCHs as well as the following 30 days whether initiated or concluded days in any Medicare setting. Describe volume of services, types, cost and payments. One question is whether or not to include physician services. The statute appears to include physicians in the definition of applicable services at least for the national bundling pilot hence the CCH model should collect information on the physician services provided as well. However, only the primary care physician, and not the consulting physicians, should be included in the bundled payment.

      Include data on outpatient therapy services in all settings as well as home health services and the others specified in the statute: care coordination; medication reconciliation, discharge planning, transitional care services and other patient centered activities as they can be identified and quantified.

      Collect data on patients included in the time frame who continue to receive Medicare services after the EOC is ended.

   b. **Patient Characteristics**
      Collect data on attributes such as diagnosis, function on admission, function on discharge, age, sex, race, co-morbidities, LOS, medical information available on admission and discharge, status prior to acute care admission, home status, SES, infection rates, and impairments. Also measure discharge destinations, death rates, planned and unplanned (preventable, avoidable) readmission rates, costs, and payments. The objective would be to compare medical and functional status among the patients currently being served in various settings. This work, at least conceptually, is part of the focus of the PAC PRD demonstration program currently underway by CMS which is referenced above.

   c. **Collection Instrument/ Codes**
      Review the inpatient CARE tool as well as those proposed for the outpatient data collection, CARE –F (for SNFs and day rehab programs) and CARE- C (for community settings) and the AM-PAC tool. Revise as needed based on the current experience from the PAC PRD, based on the principles and criteria outlined above and based on the attached example of a change to the tool. Using the modified CARE or a revised version would remove all recognized problems with different tools.
Consider collecting the data using the ICD-10–CM which is to be implemented in 2013 and/or ICF nomenclature. If data cannot be collected using the ICD-10-CM then assure that the codes collected can be cross walked to it. The ICD-10 would provide a much richer medical picture of the status of the patients.

See also the discussion in the ASPE “Post Acute Care Episode of Care.”

d. Payment /Costs/ Resource Use
The database also has to account for all payments and costs for each definition of the episode of care. This requires obtaining the information on the Medicare payment for all the services mentioned above in the time frame of the episode of care (EOC) and from all the included providers – IRH/Us, LTCHs, HSNFs for Phase I and home health, community-based SNFs, outpatient therapy providers, as well as any psychologists or social work services paid under Part B, etc for Phase II. These data include Medicare cost reports, Medicare claims, various Medicare analytical files, provider files and provider costs and the PAC PRD project CRU information. Collect payment and cost data on patients who continue to need services after the EOC is ended.

e. Refine the Data Modeling Various EOC Definitions
This step includes looking at the definitions of the EOC such as whether a defined EOC of the CCH stay plus the 30 days post discharge should be “prorated,” “fixed,” or other approaches. Both the prorated and fixed approach were explored by RTI in the PAC EOC study.

2. Analyze the Feasibility of Creating Patient Episodes of Care Including Risk Adjustment
From these data, analyze the feasibility of creating new patient episodes of care from the patient characteristics collected that would reflect function, age, diagnosis, LOS if relevant, age, status prior to onset, outcome expectations, living situation, sex, and co-morbidities for medical status, at a minimum. The conceptual and methodological approach undertaken by the RAND Corporation in the creation of the Case Mix Groups ultimately used in the Inpatient Rehabilitation Facilities Prospective Payment System (IRF PPS) is one model to follow.

Severity would be included in the creation of the groups to address the impact of single or multiple co-morbidities in lieu of tiers in order to reflect medical acuity and to provide for initial risk adjustment. Review the literature on risk adjustment in these three settings.

One key challenging factor is the variability, and range in these patients and their costs. Hence creating homogenous groups (in terms of patient characteristics and costs) with strong resource predictability and a payment to cost ratio is difficult and could result in a large number of groups which, not surprisingly, would look like a string of LTCH, MS DRGs, CMGs and RUGs. Hence, interim steps may include a) the two phased approach discussed above, paying based on current FFS costs plus shared savings incentives, and b)
experimenting in developing groups for relatively predictable cases, e.g. orthopedic, and various musculoskeletal cases.

3. **Create Patient Episode of Care Weights**
   Match the new patient episode groups with Medicare cost reports, claims data, any other information from above and the additional data from the Cost Resource Utilization tool used in the PAC PRD to create new “Patient Continuing Care Hospital Care Episode of Care Groups (CCHCGs).”

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

4. **Develop the Details of the Episode of Care: Definition and Payment Options**
   Base the CCHCGs on a per episode unit of payment –the episode of care - using the CCH length of stay and the subsequent 30 days in two phases. In phase one, the inpatient CCH episode of care would be analyzed to create payment that represented the inpatient stay in the multiple levels of post-acute care. In the second phase, data would be collected on the inpatient CCH stay plus 30 days for the complete episode of care. In addition, there are multiple issues to address even with a statutory definition of EOC. They include prorated or fixed as addressed in the ASPE Post Acute Care Episodes of Care Study. Also, patients who exhaust their Medicare days should be tracked separately after they exhaust their care to determine which costs are to be included in the EOC (see design issues above). Part of the question is whether to include all of their cost of care once they are off Medicare in the episode or just the costs associated with them for their Medicare eligible days.

   Payment options may be a one time bundled EOC payment or bid payment. **AMRPA does not recommend** using a bid payment, in which the CCH would go at risk for outcomes initially as this would result in many, if not all, potential providers declining the opportunity to participate in the demonstration project. The EOC bundle also puts the CCH at risk for delivering the care (without stinting or cherry picking) and meeting the stated quality outcomes. This is **not** recommended by AMRPA because of the lack of current data on which to base a bid.

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

6. **Provide for Adjusters and Special Payment Rules**
   Analyze the data to determine the adjustments needed for:
   a. Potential facility adjusters such as wages, LIP, rural, teaching, others.
b. Special payment rules such as transfers, short stay cases/ outliers, interrupted stays, readmissions, and high cost outliers as noted above.

c. Cost of specialized care not captured via a co-morbidity adjustment such as high cost DME, dialysis, and high cost drugs such as chemotherapy.

7. Readmissions Payment Policies
   If there is to be a readmission policy for cases readmitted from the CCH during the EOC to acute care, covered readmissions need to be defined. The current discussion looks at unplanned, avoidable readmissions. As noted above the new acute hospital readmission policy is going to include heart attack, heart failure, and pneumonia initially. The CCH readmissions need to be examined with an eye to what was unplanned and avoidable and whether there would be a payment penalty for such cases.

8. Include Performance and Quality Measures
   Performance and quality measures would need to be chosen or designed similar to those attached and which were adopted by CMS in the FY 2012 IPPS, LTCH, and IRH/U rules. Quality measures have been used by SNFs for several years. These need to be examined along with those included in the CARE tool and the MDS 3.0 measures proposed to NQF as well as the efforts of the AMRPA Quality Committee. Over time after the pilot, measures may be reported for 2 years. After that time, payment would be tied to these measures with an emphasis on providing incentives in terms of increased payment for higher quality care, such as increased functional ability on discharge even if it requires a longer length of stay.

9. Amend Existing Laws and Regulations
   Rewrite the definitions of HSNFs, LTCHs, and IRH/Us to create a category of provider known as a CCH. This would require amending the Medicare Act, regulations and adjustment by accreditation organizations, and possibly state certifying agencies and laws. See Appendix C.

10. Outcomes-Based Initiative
    After initial implementation, revise the payment system to include bonuses for better functional outcomes and other positive patient actions and outcomes.

11. Payment Outside the EOC
    Analyze the data regarding the services, payments and cost of CCH patients needing services post the EOC. Determine whether they will be paid based on the current payment models or if another should be applicable.

12. Define the Term Common Management
    Define the statutory term used with the CCH of “common management.” Examine existing health care regulations for any precedent.

13. Define Patient Care and Patient Safety Standards
    The CCH must demonstrate the ability to meet patient care and patient safety standards. These must be defined. Research current standards in the hospital conditions of participation,
JCAHO standards, and CARF standards, other accrediting bodies, RTI LTCH studies, LTCH association reports on same, and engage consensus panels.

14. Estimate Savings
Streamlining the delivery system and eliminating various administrative requirements, such as the 25% rule for LTCHs and the 60% rule and three hour rule for IRH/Us, is expected to result in savings. Similarly, eliminating admissions and discharges internal to the CCH would result in savings since there would no longer be a need for separate medical records because the care is consolidated within the CCH. Improved coordination of care is likely to reduce preventable readmissions to acute care as well as complications resulting from multiple admissions and discharges among the current silos.

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

Appendices
A. Statutory Provisions for the National Pilot Program
B. Proposed Quality Measures for the CCH Pilot
C. Statutes and Regulations to be Waived
D. Example of Revisions to the CARE Assessment Tool

Approved by the AMRPA Board of Directors, August 2, 2011.
Appendix A

Statutory Provisions for the National Pilot Program on Payment Bundling (Sec. 3023) and the CCH Pilot Test Amendment (Sec. 10308)

SEC. 3023. NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.
Title XVIII of the Social Security Act, as amended by section 3021, is amended by inserting after section 1886C the following new section:

“NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING “SEC. 1866D. (a) IMPLEMENTATION.—

“(1) IN GENERAL.—The Secretary shall establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services under this title.

“(2) DEFINITIONS.—In this section:

“(A) APPLICABLE BENEFICIARY.—The term ‘applicable beneficiary’ means an individual who—
“(i) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B of such title, but not enrolled under part C or a PACE program under section 1894; and
“(ii) is admitted to a hospital for an applicable condition.

“(B) APPLICABLE CONDITION.—The term ‘applicable condition’ means 1 or more of 8 conditions selected by the Secretary. In selecting conditions under the preceding sentence, the Secretary shall take into consideration the following factors:

“(i) Whether the conditions selected include a mix of chronic and acute conditions.

“(ii) Whether the conditions selected include a mix of surgical and medical conditions.

“(iii) Whether a condition is one for which there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished while reducing total expenditures under this title.

“(iv) Whether a condition has significant variation in—

“(I) the number of readmissions; and

“(II) the amount of expenditures for post-acute
care spending under this title.

“(v) Whether a condition is high-volume and has high post-acute care expenditures under this title.

“(vi) Which conditions the Secretary determines are most amenable to bundling across the spectrum of care given practice patterns under this title.

“(C) APPLICABLE SERVICES.—The term ‘applicable services’ means the following:

“(i) Acute care inpatient services.

“(ii) Physicians’ services delivered in and outside of an acute care hospital setting.

“(iii) Outpatient hospital services, including emergency department services.

“(iv) Post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital.

“(v) Other services the Secretary determines appropriate.

“(D) EPISODE OF CARE.—

“(i) IN GENERAL.—Subject to clause (ii), the term ‘episode of care’ means, with respect to an applicable condition and an applicable beneficiary, the period that includes—

“(I) the 3 days prior to the admission of the applicable beneficiary to a hospital for the applicable condition;

“(II) the length of stay of the applicable beneficiary in such hospital; and

“(III) the 30 days following the discharge of the applicable beneficiary from such hospital.

“(ii) ESTABLISHMENT OF PERIOD BY THE SECRETARY.—
The Secretary, as appropriate, may establish a period (other than the period described in clause (i)) for an episode of care under the pilot program.

“(E) PHYSICIANS’ SERVICES.—The term ‘physicians services’ has the meaning given such term in section 1861(q).

“(F) PILOT PROGRAM.—The term ‘pilot program’ means the pilot program under this section.

“(G) PROVIDER OF SERVICES.—The term ‘provider of services’ has the meaning given such term in section 1861(u).
“(H) READMISSION.—The term ‘readmission’ has the meaning given such term in section 1886(q)(5)(E).

“(I) SUPPLIER.—The term ‘supplier’ has the meaning given such term in section 1861(d).

“(3) DEADLINE FOR IMPLEMENTATION.—The Secretary shall establish the pilot program not later than January 1, 2013.

“(b) DEVELOPMENTAL PHASE.—

“(1) DETERMINATION OF PATIENT ASSESSMENT INSTRUMENT.—The Secretary shall determine which patient assessment instrument (such as the Continuity Assessment Record and Evaluation (CARE) tool) shall be used under the pilot program to evaluate the applicable condition of an applicable beneficiary for purposes of determining the most clinically appropriate site for the provision of post-acute care to the applicable beneficiary.

“(2) DEVELOPMENT OF QUALITY MEASURES FOR AN EPISODE OF CARE AND FOR POST-ACUTE CARE.—

“(A) IN GENERAL.—The Secretary, in consultation with the Agency for Healthcare Research and Quality and the entity with a contract under section 1890(a) of the Social Security Act, shall develop quality measures for use in the pilot program—

“(i) for episodes of care; and

“(ii) for post-acute care.

“(B) SITE-NEUTRAL POST-ACUTE CARE QUALITY MEASURES.—Any quality measures developed under subparagraph (A)(ii) shall be site-neutral.

“(C) COORDINATION WITH QUALITY MEASURE DEVELOPMENT AND ENDORSEMENT PROCEDURES.—The Secretary shall ensure that the development of quality measures under subparagraph (A) is done in a manner that is consistent with the measures developed and endorsed under section 1890 and 1890A that are applicable to all postacute care settings.

“(c) DETAILS.—

“(1) DURATION.—

“(A) IN GENERAL.—Subject to subparagraph (B), the pilot program shall be conducted for a period of 5 years.
“(B) EXTENSION.—The Secretary may extend the duration of the pilot program for providers of services and suppliers participating in the pilot program as of the day before the end of the 5-year period described in subparagraph (A), for a period determined appropriate by the Secretary, if the Secretary determines that such extension will result in improving or not reducing the quality of patient care and reducing spending under this title.

“(2) PARTICIPATING PROVIDERS OF SERVICES AND SUPPLIERS.—

“(A) IN GENERAL.—An entity comprised of providers of services and suppliers, including a hospital, a physician group, a skilled nursing facility, and a home health agency, who are otherwise participating under this title, may submit an application to the Secretary to provide applicable services to applicable individuals under this section.

“(B) REQUIREMENTS.—The Secretary shall develop requirements for entities to participate in the pilot program under this section. Such requirements shall ensure that applicable beneficiaries have an adequate choice of providers of services and suppliers under the pilot program.

“(3) PAYMENT METHODOLOGY.—

“(A) IN GENERAL.

“(i) ESTABLISHMENT OF PAYMENT METHODS.—The Secretary shall develop payment methods for the pilot program for entities participating in the pilot program. Such payment methods may include bundled payments and bids from entities for episodes of care. The Secretary shall make payments to the entity for services covered under this section.

“(ii) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments under this section for applicable items and services under this title (including payment for services described in subparagraph (B)) for applicable beneficiaries for a year shall be established in a manner that does not result in spending more for such entity for such beneficiaries than would otherwise be expended for such entity for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

“(B) INCLUSION OF CERTAIN SERVICES.—A payment methodology tested under the pilot program shall include payment for the furnishing of applicable services and other appropriate services, such as care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities as determined appropriate by the Secretary.

“(C) BUNDLED PAYMENTS.—

“(i) IN GENERAL.—A bundled payment under the pilot program shall—

“(I) be comprehensive, covering the costs of applicable services and other appropriate services furnished to an individual during an episode of care (as determined by the Secretary); and

“(II) be made to the entity which is participating in the pilot program.
“(ii) REQUIREMENT FOR PROVISION OF APPLICABLE SERVICES AND OTHER APPROPRIATE SERVICES.—
Applicable services and other appropriate services for which payment is made under this subparagraph shall be furnished or directed by the entity which is participating in the pilot program.

“(D) PAYMENT FOR POST-ACUTE CARE SERVICES AFTER THE EPISODE OF CARE.—The Secretary shall establish procedures, in the case where an applicable beneficiary requires continued post-acute care services after the last day of the episode of care, under which payment for such services shall be made.

“(4) QUALITY MEASURES.—

“(A) IN GENERAL.—The Secretary shall establish quality measures (including quality measures of process, outcome, and structure) related to care provided by entities participating in the pilot program. Quality measures established under the preceding sentence shall include measures of the following:

“(i) Functional status improvement.
“(ii) Reducing rates of avoidable hospital readmissions.
“(iii) Rates of discharge to the community
“(iv) Rates of admission to an emergency room after a hospitalization.
“(v) Incidence of health care acquired infections.
“(vi) Efficiency measures.
“(viii) Measures of patient perception of care.
“(ix) Other measures, including measures of patient outcomes, determined appropriate by the Secretary.

“(B) REPORTING ON QUALITY MEASURES.—

“(i) IN GENERAL.—A entity shall submit data to the Secretary on quality measures established under subparagraph (A) during each year of the pilot program (in a form and manner, subject to clause (iii), specified by the Secretary).

“(ii) SUBMISSION OF DATA THROUGH ELECTRONIC HEALTH RECORD.—To the extent practicable, the Secretary shall specify that data on measures be submitted under clause (i) through the use of an qualified electronic health record
(as defined in section 3000(13) of the Public Health Service Act (42 U.S.C. 300jj–11(13)) in a manner specified by the Secretary.

“(d) WAIVER.—The Secretary may waive such provisions of this title and title XI as may be necessary to carry out the pilot program.

“(e) INDEPENDENT EVALUATION AND REPORTS ON PILOT PROGRAM.—

“(1) INDEPENDENT EVALUATION.—The Secretary shall conduct an independent evaluation of the pilot program, including the extent to which the pilot program has—

“(A) improved quality measures established under subsection (c)(4)(A);

“(B) improved health outcomes;

“(C) improved applicable beneficiary access to care; and

“(D) reduced spending under this title.

“(2) REPORTS.—

“(A) INTERIM REPORT.—Not later than 2 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the initial results of the independent evaluation conducted under paragraph (1).

“(B) FINAL REPORT.—Not later than 3 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the final results of the independent evaluation conducted under paragraph (1).

“(f) CONSULTATION.—The Secretary shall consult with representatives of small rural hospitals, including critical access hospitals (as defined in section 1861(mm)(1)), regarding their participation in the pilot program. Such consultation shall include consideration of innovative methods of implementing bundled payments in hospitals described in the preceding sentence, taking into consideration any difficulties in doing so as a result of the low volume of services provided by such hospitals.

“(g) IMPLEMENTATION PLAN.—

“(1) IN GENERAL.—Not later than January 1, 2016, the Secretary shall submit a plan for the implementation of an expansion of the pilot program if the Secretary determines that such expansion will result in improving or not reducing the quality of patient care and reducing spending under this title.

“(h) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the selection, testing, and evaluation of models or the expansion of such models under this section.”
SEC. 10308. REVISIONS TO NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

(a) IN GENERAL.—Section 1866D of the Social Security Act, as added by section 3023, is amended—

(1) in paragraph (a)(2)(B), in the matter preceding clause(i), by striking “8 conditions” and inserting “10 conditions”;

(2) by striking subsection (c)(1)(B) and inserting the following:

“(B) EXPANSION.—The Secretary may, at any point after January 1, 2016, expand the duration and scope of the pilot program, to the extent determined appropriate by the Secretary, if—

“(i) the Secretary determines that such expansion is expected to—

“(I) reduce spending under title XVIII of the Social Security Act without reducing the quality of care; or

“(II) improve the quality of care and reduce spending;

“(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under such title XVIII; and

“(iii) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under this title for individuals.”; and

(3) by striking subsection (g) and inserting the following new subsection:

“(g) APPLICATION OF PILOT PROGRAM TO CONTINUING CARE HOSPITALS.—

“(1) IN GENERAL.—In conducting the pilot program, the Secretary shall apply the provisions of the program so as to separately pilot test the continuing care hospital model.

“(2) SPECIAL RULES.—In pilot testing the continuing care hospital model under paragraph (1), the following rules shall apply:

“(A) Such model shall be tested without the limitation to the conditions selected under subsection (a)(2)(B).

“(B) Notwithstanding subsection (a)(2)(D), an episode of care shall be defined as the full period that a patient stays in the continuing care hospital plus the first 30 days following discharge from such hospital.

“(3) CONTINUING CARE HOSPITAL DEFINED.—In this subsection, the term ‘continuing care hospital’ means an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation
services provided in inpatient rehabilitation hospitals and units (as defined in section 1886(d)(1)(B)(ii)), long term care hospitals (as defined in section 1886(d)(1)(B)(iv)(I)), and skilled nursing facilities (as defined in section 1819(a)) that are located in a hospital described in section 1886(d).”.

(b) TECHNICAL AMENDMENTS.—
(1) Section 3023 is amended by striking “1886C” and inserting “1866C”.

(2) Title XVIII of the Social Security Act is amended by redesignating section 1866D, as added by section 3024, as section 1866E.
## Appendix B: Proposed Quality Measures for CCH Pilot

<table>
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<tr>
<th>Measures</th>
<th>CCH</th>
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<tr>
<td>1. Functional status improvement</td>
<td>Any functional patient assessment instrument needs to meet several criteria. These include:</td>
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<td>a. It is administratively feasible to implement and not too burdensome.</td>
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<td>b. It utilizes computer adapted testing methodology.</td>
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<td>c. It covers all domains related to complex medical and medical rehabilitation care</td>
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<td>d. It provides for evaluation for patients’ long term outcomes of treatment.</td>
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<td>e. It has predictive validity and reliability.</td>
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<td>f. It has minimum floor and ceiling effects which are well identified when utilized on the patient populations in question. Patients who might be affected by these effects can generally be identified and allowance made for their treatment and admission.</td>
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<td>g. It utilizes the ICD-10-CM codes which are effective in CY 2013.</td>
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<td>h. In addition to medical and functional information and items, it incorporates the International Classification of Function components of Activity and Participation.</td>
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At a minimum a CCH functional patient assessment instrument must address: |
| a. Administrative information |
| b. Medical information including co morbidities |
| c. Functional information including motor, self care and mobility and cognitive function |
| d. Environmental factors |
| e. Social factors including activity limitations and participation restrictions using the ICF conceptual framework, which include sensory experiences, basic learning, applying knowledge, general tasks and demands, domestic life, interpersonal interactions and relationships, community, social and civic life among others. |
| f. Long term follow up for patients. |
| g. Another ideal requirement is that functional items can be mapped prior and existing tools so legacy data is still meaningful. |

**AMRPA Recommends CMS:** |
| a. consider utilizing the CARE tool for purposes of the pilot as amended to include the criteria mentioned above and in the position paper |
| b. If data cannot be collected using the ICD-10-CM then assure that the codes collected can be adequately cross walked to the ICD-10 via the GEMS. The ICD-10 would provide a much richer medical status picture of the patients. |
2. Reducing rates of avoidable hospital readmissions

Look at two measures:
   a) Avoid readmission to acute care and
   b) Avoid readmission to CCH within the EOC

See also the discussion on “Readmissions policies” in the position paper.

3. Rates of discharge to the community

Discharge to the community would be discharge rates for the episode of care. However such a measure needs to be considered carefully. Currently 35% of Medicare beneficiaries who are hospitalized and who use post acute care according to the RTI studies. One issue is that the presence of community or family supports may be a determinant when otherwise the patient could be discharged which would not be a reflection of the quality of care delivered, but external factors. The second issue is that such a measure without certain exclusions and other considerations would lead to stinting on care and skewing the original admissions.

Finally, another issue is the definition of community. Community discharges could include the following discharge sites: home, board and care, transitional living, intermediate care, and assisted living. If HHS selects such a measure, it would have to be risk-adjusted with an emphasis on assuring continued access to the CCH.

Otherwise 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/in the community 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.

4. Rates of admission to an emergency room after a hospitalization

N/A

5. Incidence of health care acquired infections

See FY 2011 Hospital Acquired Conditions

- HAC: Blood Incompatibility
- HAC: Pressure Ulcer Stages III & IV
- HAC: Falls and Trauma (Includes: Fracture, Dislocation, Intracranial Injury, Crushing Injury, Burn, Electric Shock)
- HAC: Vascular Catheter-Associated Infection
- HAC: Catheter-Associated Urinary Tract Infection (UTI)
- HAC: Manifestations of Poor Glycemic Control
There were also 4 surgical site infections listed:
- Surgical site infection mediastinitis, following coronary artery bypass graft (CABG)
- Surgical site infection following certain orthopedic procedures
- Surgical site infection following bariatric surgery for obesity
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures

(See pg. 50084, August 16, 2010 Federal Register (75 FR 157)

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<th>6. Efficiency measures</th>
<th>NQF Measure 0420, Pain Assessment Prior to Initiation of Patient Therapy</th>
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</table>
| 7. Measures of patient centeredness of care | HCAPS Measures for:
- communication about medicines, discharge instructions, pain control, responsiveness of hospital staff, overall rating of hospital care, overall recommendation, quietness of hospital, cleanliness of hospital, communication with doctors, nurses, therapists. |
| 8. Measures of patient perception of care | HCAPS + eRehabData®
Patient Satisfaction Measure Questions Not Covered by HCAPS |
| 9. Other Measures, including measures of patient outcomes, determined appropriate by the Secretary | - Mortality
- Quality reporting measures adopted per Section 3004, ACA and others provisions for IRFs, SNFs and LTCHs |
## Appendix C

### Post-Acute Care Bundling Impact on Existing Rules, Regulations, and Policies

<table>
<thead>
<tr>
<th>PROVIDER TYPE / PAYMENT SYSTEM</th>
<th>POLICY / RULE / REGULATION</th>
<th>IMPLICATIONS UNDER PAC BUNDLE (i.e., distinguish, amend, eliminate)</th>
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<tbody>
<tr>
<td>Home Health</td>
<td>Beneficiary Qualifications for Coverage</td>
<td>Home health (HH) services are covered only if furnished by a HHA participating in the Medicare program and acting on a physician’s certification that the individual meets certain requirements, such as confined to the home. <em>This policy would likely be modified to reflect that hospitals would be responsible for ensuring that the beneficiary is qualified to receive HH services. Are hospitals prepared for this additional burden?</em></td>
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<td>Qualified Home Health Agency (HHA)</td>
<td>Generally, services furnished by a HHA are not covered by Medicare unless the HHA is participating in the Medicare program (i.e., approved by Medicare and has signed a participation agreement). In addition, the HHA must meet certain other requirements, such as primarily being in the business of providing skilled nursing services and other therapeutic services. <em>How will hospitals determine whether and ensure that a HHA is qualified to provide HH services?</em></td>
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<td>Conditions of Participation (CoP)</td>
<td>HHAs seeking participation in the Medicare program are required to meet the CoPs. <em>Will hospitals be responsible for ensuring a HHA’s compliance with the CoPs? How will hospitals know how to ensure quality in a HHA?</em></td>
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<td>Home Health Services</td>
<td>HH services are certain items and services provided on a visiting basis in a place of residence used as the individual’s home. These items include: physical or occupational therapy; medical social services under the direction of a physician; and part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse. <em>HH services are defined by statute.</em> Will acute care hospitals begin providing HH services to beneficiaries to eliminate HHAs? And, if so, acute care hospitals would have to meet applicable federal and state laws to provide HH services.</td>
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<tr>
<td>Surety Bonds</td>
<td>New and existing suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) will be required to furnish CMS with a surety bond of $50,000. Although certain DMEPOS suppliers are exempted from the surety requirement, HHAs are included to the extent that they provide DME to their patients. <em>Will hospitals be responsible for posting surety bonds for HHAs that furnish DME to beneficiaries?</em></td>
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<tr>
<td>Advance Beneficiary Notices (ABNs)</td>
<td>In cases where the HHA believes that HH services ordered by a physician would not be covered by Medicare, the HHA must inform the patient orally and provide written notice in the form a HHABN. <em>If the hospital will be responsible for billing Medicare for HH services, the hospital will then be responsible for supplying HHABNs to beneficiaries. How would hospitals adjust to this additional burden?</em></td>
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<td>Plan of Care Requirements</td>
<td>The plan of care must be reviewed and signed by a physician in consultation with an HHA professional personnel no less frequently than every 60 days. <em>Will hospitals be required to ensure that HHAs comply with plan of care requirements?</em></td>
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<td>Consolidated Billing</td>
<td>All Medicare HH services ordered by the physician in a plan of care must be billed to Medicare by the HHA. The payment made to a HHA for a 60-day HH episode of care includes payment for HH services. <em>This requirement would have to be eliminated under a PAC bundle because Medicare would be reimbursing the hospital whereas this policy requires that only the HHA be reimbursed.</em></td>
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<td>Outcomes and Assessment Information Set (OASIS)</td>
<td>Medicare-certified HHAs are required to use a standard set of data items, known as OASIS as part of a comprehensive assessment for all patients who are receiving skilled care that is reimbursed by Medicare or Medicaid. OASIS data are submitted by home health agencies to the States, and subsequently transmitted to CMS. <em>Submitting OASIS data is set forth by regulation and ensures quality of care. This policy would likely be modified as hospitals would have to supply this data to CMS.</em></td>
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<td>Prospective Payment System (PPS) for Home Health Agencies</td>
<td>Generally, Medicare makes payment under the HH PPS on the basis of a national standardized 60-day episode payment rate that is adjusted for the applicable case-mix and wage index. The national standardized 60-day episode payment includes the 6 HH disciplines (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services) and non-routine medical supplies. <em>The HH PPS would possibly need to be eliminated or modified as there would be no need to adjust the rate due to the PAC bundle. In addition, payment to the hospital may no longer be based on a 60-day episode.</em></td>
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<td>Outlier Payments</td>
<td>Additional payments are made to the 60-day case mix adjusted episode payments for beneficiaries who incur unusually large costs (i.e., imputed costs exceeds a threshold amount for each case-mix group). Total national outlier payments for HH services annually will be no more than 5 percent of estimated total payments under HH PPS. <em>Will outlier payments be eliminated under a PAC bundle to ensure cost efficiency?</em></td>
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<tr>
<td>Low-Utilization Payment Adjustment (LUPA)</td>
<td>An episode with four or fewer visits is paid the national per-visit amount by discipline updated annually by the applicable market basket for each visit type. <em>Will LUPA still be reimbursed? How will it be calculated?</em></td>
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<td>Partial Episode Payment Adjustment (PEP)</td>
<td>CMS makes a PEP adjustment to the original 60-day episode payment that is interrupted by an intervening event (e.g., discharge and return to the same HHA during a 60-day period). <em>Will PEP payments still be accounted for? What will be considered an interrupted stay?</em></td>
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<td>Durable Medical Equipment (DME) Fee Schedule</td>
<td>DME covered under HH is paid under the DME fee schedule. Medicare payment for DME is equal to 80 percent of the lesser of the actual charge or the fee schedule amount for the item. Under competitive bidding, DME furnished to beneficiaries living in competitive bidding areas will be reimbursed based on a single payment. <strong>Will hospitals provide DME to HH beneficiaries?</strong> If so, <strong>will hospitals need to satisfy all of the regulatory policies (e.g., accreditation) that apply to DME suppliers?</strong></td>
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<td></td>
<td>Certificate of Need (CON)</td>
<td>CON programs are intended to restrain health care facility costs and allow coordinated planning of new services and construction. Under these laws, health care facilities are required to demonstrate the need for such facilities in the state before creating new facilities or improving existing facilities. <strong>Medicare requires that participating providers comply with applicable state laws.</strong> How will hospitals ensure that these facilities are in compliance with CON requirements, if applicable, for purposes of reimbursement? <strong>Further, a “bundled” environment will likely require acute and post-acute care providers to expand bed numbers or service lines, or build new hospitals or facilities?</strong> It is possible that many state CON laws could constrain or even preclude these types of expansions.</td>
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<td>State Licensure and Certification</td>
<td>Each state has its own requirements for the licensure and certification of health care facilities. State survey agencies routinely conduct Medicare surveys on behalf of the program. There are also a variety accrediting bodies and standards for PAC facilities. <em>Medicare requires that participating providers comply with applicable state laws.</em> How will hospitals ensure that these facilities are appropriately licensed or certified for purposes of reimbursement? How will conflicts with state laws be resolved to allow movement to a bundled environment? <em>Would state survey agencies continue to be responsible for surveying on behalf of Medicare? Will there be one accreditation body and set of standards for all PAC facilities?</em></td>
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<td>Coinsurance</td>
<td>There are no coinsurance amounts for HH services. However, when HHAs provide services not included in the definition of HH services, the coinsurance amounts do apply. For example, the 20 percent coinsurance applies to DMEPOS furnished by HHAs. <em>Under a PAC bundle, would the coinsurance for DMEPOS be modified or eliminated? Would the hospital collect the coinsurance amount?</em></td>
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<tr>
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<td>Long-Term Care Hospitals</td>
<td>Qualified Long-Term Care Hospitals</td>
<td>LTCHs are hospitals that are primarily engaged in providing inpatient services by or under the supervision of a physician, to Medicare beneficiaries with medically complex conditions who require a long hospital stay and programs of care are provided by a LTCH. The facility must have an average inpatient length of stay (LOS) greater than 25 days (or 20 days for certain hospitals focusing on cancer treatment). <em>Would there be a need for LTCHs under a PAC bundle? Would hospitals begin providing LTCH services? Would LTCHs continue to have to meet the 25-day average LOS requirements?</em></td>
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<td>Requirements for Long-Term Care Hospitals</td>
<td>LTCHs must have – (1) a documented patient review process that includes pre-admission screening, validation within 48 hours of admission, and periodic evaluation of each patient’s need for continued care in the LTCH and assessment of the available discharge options; (2) active physician involvement with patients through an organized medical staff; and (3) interdisciplinary teams of health care professionals to prepare and implement an individualized treatment plan for each patient. <em>Will hospitals be responsible for ensuring that LTCHs meet their requirements? Will hospitals become their own LTCHs?</em></td>
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<tr>
<td>3-Year Moratorium</td>
<td>Secretary imposed a 3-year moratorium on the establishment or classification of new LTCH facilities and on bed increases for existing facilities with some exceptions. <em>Would the moratorium be extended or eliminated?</em></td>
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<td>Prospective Payment System Long-Term Care Hospitals</td>
<td>Payment under the LTCH PPS is made on a per-discharge basis. Each patient case is classified according to the principal diagnosis, up to 8 additional diagnoses, and up to 6 procedures performed during the stay, as well as age, sex, and discharge status of the patient. The patient’s case is classified by MS-LTC-DRGs, based on the relative costliness of treatment in the group. The amount of the prospective payment is based on the standard federal rate, and adjusted for the MS-LTC-DRG relative weights, differences in wage levels, cost-of-living in Alaska and Hawaii, high-cost outliers, and other special payment provisions. <em>Would the LTCH PPS be eliminated as LTCHs and hospitals consolidate their facilities?</em></td>
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<td>One-Day Payment Window</td>
<td>LTCHs under the LTCH PPS are subject to the one-day payment window, or the 24-hour rule, for preadmission services. That is, outpatient diagnostic services and most nonphysician services provided during the calendar day immediately preceding the date of admission to an LTCH are included in the standard payment. Only applies if the services are diagnostic and furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient. <em>If hospitals become their own LTCHs, this policy would be modified or eliminated as there would be less need for the 24-hour rule.</em></td>
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<td>Outlier Payments</td>
<td>For unusually high costs, LTCH PPS receive increased payments. LTCHs can receive outlier payments for a case that – (1) exceeds the typical cost for a MS-LTC-DRG (“high-cost outlier); (2) has a LOS that is considerably shorter than the average LOS for a MS-LTC-DRG (“short-stay outlier”); and (3) has both unusually high costs and a considerably shorter than average LOS for a MS-LTC-DRG. <strong>Would outlier payments still be reimbursed under a PAC bundle?</strong></td>
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<td>Interrupted Stay Policy</td>
<td>Under the LTCH PPS, an interrupted stay occurs when a Medicare inpatient is transferred upon discharge to an acute care hospital, an IRF, SNF or to the patient’s home if the interruption is for 3 days or less, for treatment or services that are not available in the LTCH and returns to the same LTCH. There are two categories of interrupted stays – “3 day or less interruption of stay” and a “greater than 3 day interruption of stay.” <strong>How would an interrupted stay payment be determined under a PAC bundle?</strong></td>
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<tr>
<td>Transfers Between Co-Located Providers</td>
<td>Special payment provisions apply when an LTCH patient is transferred to a “co-located” or “onsite” facility and subsequently readmitted to the LTCH. If the number of Medicare inpatient transfers and readmissions between a LTCH and a co-located provider exceeds 5 percent of the total discharges during a cost reporting period, only one MS-LTC-DRG payment is made to the LTCH for all such discharges and readmissions. <strong>Would payments for transfers between co-located providers be eliminated?</strong></td>
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<td>Hospital-Within-Hospital Rules</td>
<td>The hospital-within-hospital rules permit hospitals that occupy space in a building also used by another hospital or in one or more separate buildings on the same campus to be exempted from the prospective payment system? <em>Will the PAC bundle permit IRFs to be located in the LTCHs?</em></td>
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<td>Special Payments</td>
<td>There are special payments for LTCHs within hospitals and satellites of LTCHs. There are also special payments for LTCHs and satellites of LTCHs that discharged Medicare patients admitted from a hospital not located in the same building or on the same campus as the LTCH or satellite of the LTCH. <em>Would these special payments be eliminated?</em></td>
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<td></td>
<td>“25 Percent Rule”</td>
<td>For cost reports beginning on or after Oct. 1, 2004, CMS may reduce the payments to LTCHs if more than 25 percent of their Medicare patients were transferred from hospitals co-located with the LTCH or a satellite facility. <em>This policy would likely be modified as it is likely that under a PAC bundle this threshold would be reached more quickly.</em></td>
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<td>Conditions of Participation</td>
<td>All hospitals, including LTCHs, are required to meet CoPs to participate in the Medicare program. <em>Will hospitals be tasked with ensuring LTCH compliance with CoPs? Will hospitals be required to comply with these CoPs if hospitals and LTCHs consolidate?</em></td>
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<td>Certificate of Need (CON)</td>
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<td>State Licensure and Certification</td>
<td>Each state has its own requirements for the licensure and certification of health care facilities. State survey agencies routinely conduct Medicare surveys on behalf of the program. There are also a variety accrediting bodies and standards for PAC facilities. <em>Medicare requires that participating providers comply with applicable state laws.</em> How will hospitals ensure that these facilities are appropriately licensed or certified for purposes of reimbursement? How will conflicts with state laws be resolved to allow movement to a bundled environment? Would state survey agencies continue to be responsible for surveying on behalf of Medicare? Will there be one accreditation body and set of standards for all PAC facilities?</td>
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<td>Coinsurance</td>
<td>For inpatient hospital stays, the beneficiary is required to pay one quarter of the inpatient hospital deductible for days 61 through 90 and one half for the 60 lifetime reserve days (days 91-150). Under a PAC bundle, would this formula be modified or eliminated? Would the hospital collect the coinsurance amounts?</td>
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<td>Inpatient Rehabilitation Facility (IRF)</td>
<td>Payment System – IRF-PPS</td>
<td>The Balanced Budget Act of 1997 (“BBA”) enacted a prospective payment system for IRF care that pays a federal per diem rate for covered IRF services. Patient comorbidities that satisfy the criteria specified in 42 CFR 412.23(b)(2)(i) shall be included in the calculations used to determine whether an IRF meets the 60 percent compliance percentage for cost reporting periods beginning on or after July 1, 2007. Under a new PAC bundle, it is likely that the IRF PPS would have to be eliminated or modified substantially.</td>
</tr>
<tr>
<td>Conditions for Coverage</td>
<td>To participate in the Medicare program, providers and suppliers of health services must comply with statutory requirements and other rules pertaining to the health and safety of Medicare beneficiaries promulgated by the Secretary, as authorized by Title XVIII of the Social Security Act. Under a new PAC bundle, who would be responsible for ensuring that the facility meets the conditions for coverage? Additionally, what conditions would change given that the hospital will be the decision-maker on what post acute care services or facilities the beneficiary require (i.e., conditions related to a patient’s plan of care, treatment, etc.).</td>
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<td>IRF Classification Criteria – “CMS 13”</td>
<td>A facility may be classified as an IRF if it has been excluded from diagnosis-related group (DRG) based acute care hospital PPS and if it treats at least one of 13 conditions. Under a PAC bundle, would the IRF classification criteria be the same? Are the 13 conditions still relevant? Who is responsible – the acute care hospital, IRF, or other entity – for ensuring that the classification criteria is met?</td>
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<td>Compliance Threshold – “60% Rule”</td>
<td>A minimum percentage of the facility’s total inpatient population must require intensive rehabilitative services for the treatment of one of 13 medical conditions. The Medicare, Medicaid, and SCHIP Extension Act (“MMSEA”) of 2007 permanently froze the compliance threshold at 60 percent, effective for cost reporting periods beginning on or after July 1, 2006. Under a PAC bundle, would the 60% Rule (formerly 75% Rule) still apply to IRFs? Would an expected decrease in volume of patients referred to an IRF require modifying the 60% Rule? If the 60% Rule still applies, is the acute care hospital, IRF, or other entity responsible for determining whether the 60% Rule is fulfilled?</td>
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<td>Coverage – “3-Hour Threshold”</td>
<td>The general threshold for establishing the need for IRF services is that the patient must require and receive at least three hours a day for physical and/or occupational therapy. Under a PAC bundle, would the “3-Hour Threshold” still apply? If so, who is responsible for determining whether the “3-Hour Threshold” is met?</td>
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<tr>
<td>Coverage – Physician Supervision</td>
<td>Patients must require close medical supervision by a physician with training or experience in rehabilitation. Currently, many Medicare contractors interpret this to mean that the patient must have non-rehabilitation comorbidities that would warrant admission to an acute inpatient unit, regardless of the patient’s functional deficits or other rehabilitation needs. Under a PAC bundle, who would determine the level of physician supervision that is needed during rehabilitation?</td>
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<td>Patient Assessment – “IRF-PAI”</td>
<td>IRFs are required to complete the inpatient rehabilitation facility patient assessment instrument (“IRF-PAI”) upon admission and discharge for all Medicare Part A fee-for-service patients who are inpatients or who are admitted or discharged on or after January 1, 2002. Medicare Part A fee-for-service IRF patient must be assessed twice by an IRF clinician using the IRF PAI. Under a PAC bundle, will the IRF-PAI still be used as a patient assessment tool? If so, who is responsible – the acute care hospital, IRF, or other entity – for completing the IRF-PAI (given that the hospital will determine whether a beneficiary should be admitted to an IRF)? Will the requirement to transmit the IRF-PAI still be required?</td>
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<td>Patient Assessment – “Case-Mix Group”</td>
<td>Based on data received from IRF-PAI, each patient will be placed into a case-mix group (&quot;CMG&quot;). Each CMG is a functional-related group, determined by distinguishing classes of IRF patient discharges on the basis of impairment, age, comorbidities, functional capability of the patient, and other factors. The CMG determines the base payment rate that the IRF receives for the Medicare-covered Part A services furnished by the IRF during the beneficiary’s episode of care. <strong>Under the PAC bundle, will case-mix groups be eliminated? Is there even a need for CMGs given that they are related to IRF payment under the IRF PPS, which likely will be eliminated?</strong></td>
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<td>Discharge Assessment</td>
<td>The discharge assessment, on the day the patient is discharged or stops receiving Medicare Part A inpatient rehabilitation services before being discharged from the hospital, is used to determine the relative weighting factors, if applicable, associated with comorbidities. Patient assessment data must be computerized and electronically reported to CMS, transmitted only once and at the same time for all patient assessment data for both the admission and discharge assessment, including any interruption in stay data. <strong>Under a PAC bundle, will the discharge assessment still be used given that it is used to determine IRF payment as part of the IRF PPS- which likely will be eliminated? If so, who is responsible – the acute care hospital, IRF, or other entity – for completing the discharge assessment?</strong></td>
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<td>Payment Adjustments – Facility-Level, Case-Level, and Outlier Adjustments</td>
<td>The IRF PPS is applied subjectively, on a case-by-case basis. Adjustments to the payment rate include facility-level adjustments, case-level adjustments and outlier adjustments. Under the IRF-PPS, will IRF-PPS payment adjustment be eliminated, given that the PAC bundle will replace the IRF-PPS? If so, how will facility-level, case-level, and outlier adjustments to the PAC bundle be accounted for?</td>
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<td>One-Day Payment Window – “24 Hour Rule”</td>
<td>Under IRF PPS, IRFs are subject to a one-day payment window, or the “24-hour Rule” for pre-admission services. Under a PAC bundle, how will pre-admission services be accounted for? Will the 24-Hour Rule still apply?</td>
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<td>Certificate of Need (CON)</td>
<td>CON programs are intended to restrain health care facility costs and allow coordinated planning of new services and construction. Under these laws, health care facilities are required to demonstrate the need for such facilities in the state before creating new facilities or improving existing facilities. Medicare requires that participating providers comply with applicable state laws. How will hospitals ensure that these facilities are in compliance with CON requirements, if applicable, for purposes of reimbursement? Further, a “bundled” environment will likely require acute and post-acute care providers to expand bed numbers or service lines, or build new hospitals or facilities? It is possible that many state CON laws could constrain or even preclude these types of expansions.</td>
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<td>State Licensure and Certification</td>
<td>Each state has its own requirements for the licensure and certification of health care facilities. State survey agencies routinely conduct Medicare surveys on behalf of the program. There are also a variety accrediting bodies and standards for PAC facilities. <em>Medicare requires that participating providers comply with applicable state laws.</em> How will hospitals ensure that these facilities are appropriately licensed or certified for purposes of reimbursement? How will conflicts with state laws be resolved to allow movement to a bundled environment? Would state survey agencies continue to be responsible for surveying on behalf of Medicare? Will there be one accreditation body and set of standards for all PAC facilities?</td>
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<td>Coinsurance</td>
<td>For inpatient hospital stays, the beneficiary is required to pay one quarter of the inpatient hospital deductible for days 61 through 90 and one half for the 60 lifetime reserve days (days 91-150). <em>Under a PAC bundle, would this formula be modified or eliminated? Would the hospital collect the coinsurance amounts?</em></td>
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<td>Skilled Nursing Facility (SNF)</td>
<td>Payment System - SNF PPS</td>
<td>The Balanced Budget Act of 1997 (“BBA”) enacted a prospective payment system for SNF care that pays a federal per diem rate for covered SNF services. <em>Under a new PAC bundle, it is likely that the SNF PPS would have to be eliminated.</em></td>
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<td>Conditions for Coverage – “Requirements for SNFs”</td>
<td>To participate in the Medicare program, providers and suppliers of health services must comply with statutory requirements and other rules pertaining to the health and safety of Medicare beneficiaries promulgated by the Secretary, as authorized by Title XVIII of the Social Security Act. These requirements are termed “conditions of participation” (“CoPs”). SNFs are subject to “requirements for SNFs” rather than CoPs. Under a new PAC bundle, who would be responsible for ensuring that the SNF meets the conditions for coverage? Additionally, what conditions would change given that the hospital will be the decision-maker on what post acute care services or facilities the beneficiary require (i.e., conditions related to a patient’s plan of care, etc.).</td>
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<td>Case-Mix Adjustment</td>
<td>The federal per diem payment rate is case-mix adjusted to account for the relative resource utilization of different patients. The SNF case-mix adjusted payment system measures the intensity of care, such as hours of nursing or therapy time needed per day, and services required, such as requirement of a ventilator, for each resident and then translates it into a specific payment level. Under a PAC bundling system, will the case-mix adjustment be eliminated given that it is likely that the SNF PPS will be eliminated. If so, how will the relative resource utilization of different patients using a SNF be accounted for?</td>
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<td>SNF Classification – Resource Utilization Groups</td>
<td>The RUG classification system is a system for classifying SNF residents into mutually exclusive groups based on clinical, functional, and resource-based criteria. The system uses beneficiary assessment data from the Minimum Data Set (“MDS”) completed by SNFs to assign beneficiaries to one of 53 RUG-III groups. Under a PAC-bundle, will the RUG classification system be eliminated? Will SNF patients still be classified based on RUGs?</td>
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<td>Minimum Data Set (“MDS”)</td>
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<td>MDS 2.0, which is a resident assessment instrument used by SNFs to assess patient needs and create a plan of treatment, is used to classify patients into RUG-III groups. The MDS contains a core set of screening, clinical, and functional status elements, including common definitions and coding categories, that form the basis of a comprehensive assessment. The amount reimbursed to the nursing home for care of a particular patient is adjusted for the clinical condition of the patient. Under a PAC bundle, will the MDS system be modified or eliminated? If not, will the SNF still be required to complete the MDS or will acute-care hospitals be responsible? If the MDS will be eliminated, how will the patient assessment and plan of treatment be accounted for?</td>
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<td>Patient Assessment – Eligibility Requirements (&quot;3-Day&quot; Rule; Transfer Rule)</td>
<td>To be eligible for SNF coverage, a beneficiary must have been inpatient of a hospital for at least three consecutive calendar days. The beneficiary also must have been transferred to a participating SNF within 30 days after discharge from the hospital. <strong>Under a PAC bundle, will the “3-Day” rule still apply?</strong> Additionally, <strong>will the transfer rule still apply (e.g., beneficiary must be transferred to a SNF within 30-days after discharge from a hospital)?</strong></td>
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<td>Medically Predictable Deferred Care</td>
<td>In some cases where it is medically predictable that a patient will require a covered level of SNF care within a predeterminable time frame, the individual may also have a need for a covered level of SNF care within 30 days of hospital discharge. In such situations, this need for covered SNF care does not negate further coverage at a future date even if there is a noncovered interval of more than 30 days between the two stays, provided all other requirements are met. <strong>Under a PAC bundle, will this deferred coverage still be available to beneficiaries?</strong></td>
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<td>Covered Services</td>
<td>Covered services under SNF PPS include Part A SNF benefits, as well as certain services for which payment may be made under Part B during a period in which the beneficiary is provided SNF care. To be covered, the SNF care services must be needed for a condition that was treated during the previous hospital stay, or for a condition that arose while in the SNF for treatment of a covered condition. <strong>Under a PAC bundle, will the definition of SNF “covered service” be modified?</strong></td>
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<td>Consolidated Billing Requirements</td>
<td>Effective for items and services provided on or after July 1, 1998, SNFs are required to consolidate</td>
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<td>billing for Medicare Part A and Part B services, with certain exceptions. SNF PPS claims are sent to the intermediary on Form CMS-1450. <em>Under a PAC bundle, will the consolidated billing requirement be modified or eliminated given that under a PAC bundle Medicare would be reimbursing the hospital whereas this policy requires that the SNF be reimbursed?</em></td>
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<td>HIV / AIDS Adjustment</td>
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<td><em>Starting in 2007, SNF payment rates also include a special adjustment made to cover the additional services required by nursing home residents with HIV/AIDS. Under a PAC bundle, how will the HIV/AIDS adjustment be accounted for given that the SNF PPS will likely be eliminated?</em></td>
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<td>Swing-Bed Facilities</td>
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<td><em>Soc. Sec. Act §1883(a)(1) allows certain small, rural hospitals to enter into a Medicare swing-bed agreement, under which the hospital can use its beds to provide either acute or SNF care, as needed. If these services are furnished by non-CAH rural hospitals, then they are paid under the SNF PPS, effective with cost reporting periods beginning on or after July 1, 2002. The swing-bed provision represents a hybrid benefit, and although the services furnished are SNF services, the provider of services is a hospital and as such is subject to hospital requirements. Under a PAC bundle, how will swing-bed facilities furnished by non-CAH rural hospitals be paid for given that the SNF PPS will likely be eliminated?</em></td>
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<td>facilities or improving existing facilities. Medicare requires that participating providers comply with applicable state laws. How will hospitals ensure that these facilities are in compliance with CON requirements, if applicable, for purposes of reimbursement? Further, a “bundled” environment will likely require acute and post-acute care providers to expand bed numbers or service lines, or build new hospitals or facilities? It is possible that many state CON laws could constrain or even preclude these types of expansions.</td>
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<td>Coinsurance</td>
<td>The beneficiary is required to pay a coinsurance of one-eighth of the inpatient hospital deductible for each day after the 20th and before the 101st day of SNF services furnished during a spell of illness. Under a PAC bundle, would this formula be modified or eliminated? Would the hospital collect the coinsurance amounts?</td>
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<td>Post-Acute Facilities</td>
<td>Patient Choice Issues</td>
<td>Federal and state laws protect a patient’s right to</td>
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<td>PROVIDER TYPE / PAYMENT SYSTEM</td>
<td>POLICY / RULE / REGULATION</td>
<td>IMPLICATIONS UNDER PAC BUNDLE (i.e., distinguish, amend, eliminate)</td>
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<td>choose their health care provider. A new “bundled” system could effectively determine site of service for post-acute services, thereby substantially infringing upon a patient’s right to choose his or her provider. CMS has developed (at considerable expense) extensive rating systems for skilled nursing facilities (i.e., Nursing Home Compare and 5 Star). These programs are designed as mechanisms to influence quality of care and as a ratings system to guide beneficiaries in SNF choices. <strong>However, since bundling could substantially impact a patient’s ability to choose a SNF, it is likely that these programs would need to be substantially modified or eliminated (and there are no data points for a unified acute/post-acute system).</strong></td>
</tr>
<tr>
<td>All Post-Acute Care Facilities</td>
<td>Must Contract Provisions, Any Willing Provider Laws (“AWP”)</td>
<td>Regulators may need to create AWP regulations and standards to ensure that post-acute care providers who are qualified under state law, who practice within the general geographic area served by the hospital, and who are willing to meet standard terms and conditions, would not be effectively precluded from providing care and services in a bundled environment. <strong>Who picks “losers and winners” and will regulators allow acute-care hospitals to engage in selective contracting? Will regulators appreciate that the survival of many post-acute providers may rest on these types of protections?</strong></td>
</tr>
<tr>
<td>Post-Acute Facilities</td>
<td>Medicare Appeals/Claims Denials/Accountability</td>
<td>DRG bundled payments for all services, including post-acute care, are determined on the basis of a beneficiary’s discharge from an acute-care stay. Bundling would, presumably, reduce payment (to acute hospitals) for readmissions to hospitals. All post-acute services will be paid on a contractual</td>
</tr>
<tr>
<td>PROVIDER TYPE / PAYMENT SYSTEM</td>
<td>POLICY / RULE / REGULATION</td>
<td>IMPLICATIONS UNDER PAC BUNDLE (i.e., distinguish, amend, eliminate)</td>
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<tr>
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<tr>
<td>Post-Acute Facilities</td>
<td>Acute Care Hospital Transfers to Post-Acute Care Hospitals</td>
<td>How will regulators change the extensive Medicare beneficiary appeals process to account for denials on non-covered, inadequate, medically unnecessary or inappropriate care that occurs in the post-acute setting? Stated otherwise, how will regulators challenge improper claims when there is no payment “hook?” How would post-acute providers protect their rights? Contractually? Is a separate Medicare appeals process necessary?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POLICY</th>
<th>CITATION</th>
<th>IMPLICATIONS UNDER PAC BUNDLE (i.e., distinguish, amend, eliminate)</th>
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</thead>
<tbody>
<tr>
<td>Physician Self-Referral Law (“Stark”)</td>
<td>42 USC §1395nn [SSA §1877]; 42 CFR Pt. 411, Subpt. J</td>
<td>The Stark Law, a strict liability statute, prohibits physicians from referring Medicare patients for certain designated health services (DHS) (e.g., home health services and inpatient and outpatient hospital services) to an entity with which the physician or member of the physician’s immediate family has a financial relationship (ownership, investment or compensation), unless an exception applies. The Law also prohibits an entity from presenting or causing to be presented a bill or claim to anyone for a DHS furnished as a result of a prohibited referral. The Stark Law would be implicated, for example, in any case where a physician at a hospital referred its patient to a home health agency (HHA) for home health services if the physician had a financial relationship with the HHA. It is likely that more of these relationships would exist in light of the PAC bundle. Thus, existing exceptions would need to be modified or new exceptions created to account for these relationships.</td>
</tr>
<tr>
<td>POLICY</td>
<td>CITATION</td>
<td>IMPLICATIONS UNDER PAC BUNDLE (i.e., distinguish, amend, eliminate)</td>
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<tr>
<td>Anti-Kickback Statute</td>
<td>42 USC §1320a-7b [SSA §1128B(b)]; 42 CFR §1001.952</td>
<td>The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any “remuneration” to induce or reward referrals of items or services reimbursable by a Federal health care program. “Remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. There are certain arrangements that are safe harbored under the statute. To qualify for safe harbor protection, an arrangement must fit squarely in one of these safe harbor provisions. The Anti-Kickback Statute would be implicated, for example, in any case where a post acute care provider offered remuneration to the hospital in order to obtain the hospital’s business. Under a bundling paradigm, it is likely that existing safe harbors will need to be modified or new safe harbors will need to be crafted to account for arrangements (e.g., contractual joint ventures) between hospitals and post acute care providers so not to violate the statute.</td>
</tr>
<tr>
<td>Civil Monetary Penalty</td>
<td>42 USC §1320a-7a [SSA § 1128A]; 42 CFR §1003.102</td>
<td>The civil monetary penalties law authorizes the imposition of civil monetary penalties for certain types of conduct, such as violating the Anti-Kickback Statute or the filing false claims. Implications under the Anti-Kickback Statute and other improper conduct that may result due to the PAC bundle may require the imposition of civil monetary penalties on the hospital and the post acute care provider. Will the OIG have the resources to oversee these new arrangements between hospitals and post acute care providers?</td>
</tr>
</tbody>
</table>
Appendix D

Continuing Care Hospital Assessment 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.

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Credential</th>
<th>License #</th>
<th>Sections Completed</th>
<th>Date(s) of Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex. Mary Smith</td>
<td>RN</td>
<td>12345</td>
<td>Body Function</td>
<td>MM/DD/YYYY</td>
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</table>
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: In the last 2 months, what other medical services besides those identified (left) has the patient used? (Check all that apply)

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. Inpatient Rehab Facility
9. Skilled Nursing Facility
10. Long Term Nursing Facility
11. Psychiatric Hospital or Unit
12. Home Health Agency
13. Hospice
14. Outpatient Services
15. 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? What help was used?

- Lives alone
- No help received or necessary
- Lives with Spouse
- Unpaid assistance
- Lives with Parents
- Paid assistance
- Lives with Siblings or other family
- Unknown
- Lives with others (specify) ______________
- Lives with paid helper
- 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  ____ Self Care – bathing, dressing, eating, toileting
1 = Mild Impairment  ____ Indoor Mobility (Walking) – room to room with/without devices
2 = Moderate Impairment  ____ Stairs (Walking) – internal/external – with/without devices
3 = Severe Impairment  ____ Community Mobility (Walking) – shopping, etc.
4 = Complete Impairment  ____ Indoor Mobility (WC) – room to room with wheeled device
8 = Not Specified  ____ Community Mobility (WC) – shopping, etc.
9 = Not Applicable  ____ 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

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<td>14.</td>
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<td>15.</td>
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</table>

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

<table>
<thead>
<tr>
<th>Allergies/Causes of Reaction</th>
<th>Patient Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.a</td>
<td>1.b</td>
</tr>
<tr>
<td>2.a</td>
<td>2.b</td>
</tr>
<tr>
<td>3.a</td>
<td>3.b</td>
</tr>
</tbody>
</table>
### 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**

<table>
<thead>
<tr>
<th>Date</th>
<th>Values (xxx.x)</th>
<th>Check if not tested</th>
<th>Check if Estimated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Height</td>
<td>□ in □ cm</td>
<td></td>
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<tr>
<td>2. Weight</td>
<td>□ lb □ kg</td>
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</tbody>
</table>

**Other Physiologic Measurements**

<table>
<thead>
<tr>
<th>Date</th>
<th>Value – use format listed</th>
<th>Check if not tested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature</td>
<td>xxx.x □ ◦F □ ◦ C</td>
<td></td>
</tr>
<tr>
<td>Heart Rate (beats/min)</td>
<td>xxx</td>
<td></td>
</tr>
<tr>
<td>Respiratory Rate (breaths/min)</td>
<td>xx</td>
<td></td>
</tr>
<tr>
<td>Blood Pressure (mm/HG)</td>
<td>xxx/xxx</td>
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<tr>
<td>O2 Saturation (Pulse Oximetry) %</td>
<td>xxx%</td>
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</table>

Specify source of O2 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.xxx |                    |
| 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?  ____ Does this patient have one or more unhealed pressure ulcer(s) at stage 2 or higher or unstageable?

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  
0 = No  
1 = Yes

<table>
<thead>
<tr>
<th>Coding</th>
<th>Number present at Admission</th>
<th>Pressure Ulcer Description</th>
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<tbody>
<tr>
<td>Please specify the number of ulcers at each stage:</td>
<td></td>
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<tr>
<td>0 = 0 ulcers</td>
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<td>1 = 1 ulcer</td>
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<td>2 = 2 ulcers</td>
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<td>3 = 3 ulcers</td>
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<td>4 = 4 ulcers</td>
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<td>5 = 5 ulcers</td>
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<td>6 = 6 ulcers</td>
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<td>7 = 7 ulcers</td>
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<td>8 = 8 or more ulcers</td>
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<tr>
<td>9 = Unknown</td>
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<td>Stage 2:</td>
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<td>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.)</td>
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<td>Stage 3</td>
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<td>Stage 3 – Full thickness tissue loss. Subcutaneous fat may be 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.</td>
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<td>Stage 4</td>
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<td>Stage 4 – Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.</td>
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<td>Unstageable</td>
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<td>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.</td>
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_____ 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:

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<th>Description</th>
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<td></td>
<td>Longest length in any direction (enter 99.9 if the largest ulcer is unstageable and is not eschar)</td>
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<td>Width of same unhealed ulcer or eschar (enter 99.9 if the largest ulcer is unstageable and is not eschar)</td>
</tr>
<tr>
<td></td>
<td>Depth of same unhealed ulcer or eschar (enter 99.9 if the largest ulcer is unstageable and is not eschar)</td>
</tr>
</tbody>
</table>

Date Measured

| MM DD YYYY | Date of the measurement |

Number of Major Wounds
(excluding pressure ulcers)

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<thead>
<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td></td>
<td>Delayed healing of surgical wound</td>
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<td></td>
<td>Trauma-related wound (e.g. burn)</td>
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<td>Diabetic food ulcer (s) Including diabetic ulcers not on the foot)</td>
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<td>Vascular ulcer (arterial or venous)</td>
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<td></td>
<td>Other (e.g. incontinence associated dermatitis, normal surgical wound healing)</td>
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</tbody>
</table>

Turning Surfaces Not Intact

Have either a pressure ulcer or major wound:

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<th></th>
<th>Description</th>
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<tbody>
<tr>
<td></td>
<td>Skin for all turning surfaces is intact</td>
</tr>
<tr>
<td></td>
<td>Right hip not intact</td>
</tr>
<tr>
<td></td>
<td>Left hip not intact</td>
</tr>
<tr>
<td></td>
<td>Back/buttocks not intact</td>
</tr>
<tr>
<td></td>
<td>Other turning surface(s) not intact</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ventilator – full time</td>
</tr>
<tr>
<td></td>
<td>Ventilator – night only</td>
</tr>
<tr>
<td></td>
<td>BIPAP</td>
</tr>
<tr>
<td></td>
<td>CPAP</td>
</tr>
<tr>
<td></td>
<td>Tracheostomy</td>
</tr>
<tr>
<td></td>
<td>Bronchitis</td>
</tr>
<tr>
<td></td>
<td>Pneumonia</td>
</tr>
<tr>
<td></td>
<td>COPD</td>
</tr>
<tr>
<td></td>
<td>Shortness of Breath</td>
</tr>
<tr>
<td></td>
<td>Asthma</td>
</tr>
<tr>
<td></td>
<td>Oxygen Use</td>
</tr>
<tr>
<td></td>
<td>Inhaler Use</td>
</tr>
<tr>
<td></td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

Impairment:

Score (ICF)

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = No Impairment (0-4%)</td>
<td></td>
</tr>
<tr>
<td>1 = Mild Impairment (5-24%)</td>
<td></td>
</tr>
<tr>
<td>2 = Moderate Impairment (25-49%)</td>
<td></td>
</tr>
<tr>
<td>3 = Severe Impairment (50-95%)</td>
<td></td>
</tr>
<tr>
<td>4 = Complete Impairment (96-100%)</td>
<td></td>
</tr>
<tr>
<td>5 = Not specified</td>
<td></td>
</tr>
<tr>
<td>6 = Not applicable</td>
<td></td>
</tr>
</tbody>
</table>

Use the ICF Rating Scale unless otherwise instructed:

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

<table>
<thead>
<tr>
<th>Score (ICF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring health status – ability to monitor respiratory rate and know when to get help</td>
</tr>
<tr>
<td>Self-Administering treatments – ability to administer basic respiratory treatments/technology (e.g. CPAP, O2, Inhalers, Aerosols)</td>
</tr>
<tr>
<td>Management of Trach – Able to connect/disconnect PMV and perform cleaning/maintenance or to direct a caregiver to do so</td>
</tr>
<tr>
<td>Management of Vent – Able to connect/disconnect vent and perform cleaning/maintenance or to direct a caregiver to do so</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Independent with respiratory management in the individual’s unique community, school and/or work environments.</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Score (ICF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sucking – drawing into the mouth by a suction force produced by movements of the cheeks, lips and tongue</td>
</tr>
<tr>
<td>Biting – cutting into, piercing or tearing off food with the front teeth</td>
</tr>
<tr>
<td>Chewing – crushing, grinding and masticating food with the back teeth (e.g. molars)</td>
</tr>
<tr>
<td>Manipulation of food in the mouth – moving food around the mouth with the teeth and tongue</td>
</tr>
<tr>
<td>Manage oral secretions (e.g. drooling, excessive oral dryness)</td>
</tr>
<tr>
<td>Oral Swallowing – clearing food and drink from the oral cavity at an appropriate rate and speed</td>
</tr>
</tbody>
</table>

**Use the ICF Rating Scale unless otherwise instructed:**

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

<table>
<thead>
<tr>
<th>Score (ICF)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

**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:**

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1 = Mild Impairment (5-24%)  8 = Not specified
2 = Moderate Impairment (25-49%)  9 = Not applicable
3 = Severe Impairment (50-95%)
<table>
<thead>
<tr>
<th>Activity Limitations &amp; Participation Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Score (ICF)</strong></td>
</tr>
<tr>
<td>Medical Monitoring – able to self-monitor key physiologic metrics (e.g. FBS, BP) or direct caregiver</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Medication Management – knowledge of medications, dosages, storage, and can independently manage or direct caregiver</td>
</tr>
<tr>
<td>Communication of Health – manages a personal health profile, keeping it up to date and available</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Score (ICF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep-Wake Cycle – able to stay awake for 4 hour time periods during normal daytime cycle</td>
</tr>
<tr>
<td>Sitting Tolerance – able to sit for an hour at a time</td>
</tr>
<tr>
<td>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”)</td>
</tr>
<tr>
<td>Physical Activity – able to tolerate minimum 3 hours of activity throughout the day, with rest breaks</td>
</tr>
<tr>
<td>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”.</td>
</tr>
<tr>
<td>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)</td>
</tr>
</tbody>
</table>

**Use the ICF Rating Scale unless otherwise instructed:**

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1 = Mild Impairment (5-24%)  
2 = Moderate Impairment (25-49%)  
3 = Severe Impairment (50-95%)  
4 = Complete Impairment (96-100%)  
8 = Not specified  
9 = Not applicable

**Activity Limitations & Participation Restrictions**

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

**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

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

**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
- □ Retinitis Pigmentosa
- □ Double Vision
- □ Other (specify)__________
- □ Eye socket injury
- □ Eye ball injury
- □ Macular Degeneration
- □ Cateracts
- □ Diabetic LV?
- □ Eye(s) missing
- □ Blurry Vision
- □ Visual Neglect
- □ Heminanopsia
- □ Macular Degeneration
- □ Cateracts
- □ Diabetic LV?
- □ Eye(s) missing
- □ Blurry Vision
- □ Visual Neglect
- □ Heminanopsia
- □ Other (specify)__________

**Impairments**

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

**Use the ICF Rating Scale unless otherwise instructed:**

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

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

### Activity Limitations & Participation Restrictions

<table>
<thead>
<tr>
<th>Score (ICF)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Ability to don and doff, change batteries and maintain hearing aids</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Auditory Compensation</strong> - 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</td>
</tr>
<tr>
<td></td>
<td><strong>Auditory Attention</strong> – ability to attend and sustain auditory attention to environment and/or functional task necessary for the individual’s life role (school, work, leisure activity)</td>
</tr>
<tr>
<td></td>
<td><strong>Use of Technology – Basic</strong> - 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)</td>
</tr>
<tr>
<td></td>
<td><strong>Use of Technology – Work/school</strong> – ability to use assistive technology for success in the individual’s school or work environment and life role.</td>
</tr>
</tbody>
</table>

### 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:

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- 3 = Severe Impairment (50-95%)
- 4 = Complete Impairment (96-100%)
- 8 = Not specified
- 9 = Not applicable
## Impairments

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

## 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%)
- 1 = Mild Impairment (5-24%)
- 2 = Moderate Impairment (25-49%)
- 3 = Severe Impairment (50-95%)
- 4 = Complete Impairment (96-100%)
- 8 = Not specified
- 9 = Not applicable
**Body Function & Structure: (ICF Score)**  
Do we need these, or are they listed as co-morbidities?

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

**Impairments**

<table>
<thead>
<tr>
<th>Bladder</th>
<th>Bowel</th>
<th>Rating Scale</th>
</tr>
</thead>
</table>
|         |       | 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:**

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4 = Complete Impairment (96-100%)  
8 = Not specified  
9 = Not applicable
<table>
<thead>
<tr>
<th>Activity Limitations (ICF Scale)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bladder</strong></td>
</tr>
<tr>
<td><em>External Device</em> (e.g. urinal, bedpan, incontinence pads/undergarments): Ability to set up, empty, clean up and maintain device.*</td>
</tr>
<tr>
<td><em>Intermittent Catheterization:</em> Ability to set up, insert, remove, clean up, follow catheterization schedule, and monitor fluid intake.*</td>
</tr>
<tr>
<td><em>Colostomy/Ostomy:</em> The ability to empty, change and properly care for colostomy or ostomy site.*</td>
</tr>
<tr>
<td><em>Neurogenic Bowel Care Program:</em> The ability to perform all steps of a neurogenic bowel care routine as recommended.*</td>
</tr>
</tbody>
</table>

| **Bowel**                     |
| *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)*  |

| **Toileting**                 |
| *Indicating need for toileting*  |
| *Transferring on/off the toilet or commode*  |
| *Manipulating clothing before and after toileting*  |
| *Cleaning oneself after toileting*  |

<table>
<thead>
<tr>
<th>Participation Restrictions (ICF Scale)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Score (ICF)</strong></td>
</tr>
<tr>
<td><strong>Participation Items</strong></td>
</tr>
<tr>
<td><em>External Devices:</em> Ability to perform or to direct caregivers regarding use of external devices*</td>
</tr>
<tr>
<td><em>Intermittent Catheterization:</em> Ability to perform or to direct caregivers regarding process for intermittent catheterization*</td>
</tr>
<tr>
<td><em>Colostomy/Ostomy:</em> Ability to perform or to direct caregivers regarding care of colostomy/ostomy.*</td>
</tr>
<tr>
<td><em>Neurogenic Bowel Care:</em> Ability to perform or to direct caregivers regarding process for bowel program*</td>
</tr>
<tr>
<td><em>Adaptive Equipment:</em> 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.*</td>
</tr>
<tr>
<td><em>Adaptive Strategies:</em> 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.*</td>
</tr>
<tr>
<td><em>Toilet transfers:</em> Ability to perform or to direct a caregiver regarding toilet transfer techniques*</td>
</tr>
<tr>
<td><em>Ability to perform or direct caregivers regarding toileting in a community, work or school setting.</em></td>
</tr>
</tbody>
</table>

**Use the ICF Rating Scale unless otherwise instructed:**

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

A. Consciousness

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

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

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

<table>
<thead>
<tr>
<th>Score (ICF)</th>
<th>Time – awareness of day, date, month and year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Place – awareness of one’s location (immediate surroundings, town, country)</td>
</tr>
<tr>
<td></td>
<td>Person – awareness of own’s own identity</td>
</tr>
<tr>
<td></td>
<td>Others – awareness of identity of individuals in one’s immediate environment</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Score (ICF)</th>
<th>Sustaining attention – concentration for the period of time required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Shifting attention – ability to refocus concentration from one stimulus to another</td>
</tr>
<tr>
<td></td>
<td>Dividing attention – ability to focus on two or more stimuli at the same time</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Score (ICF)</th>
<th>Short Term – a temporary, disruptable memory store of around 30 seconds duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Long term – ability to convert short term to long term storage of both autobiographical memory (past events) and semantic memory (language and facts)</td>
</tr>
<tr>
<td></td>
<td>Retrieval – ability to recall information stored in long-term memory and bring into awareness</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Score (ICF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pace – speed of thinking process</td>
</tr>
<tr>
<td>Form – organization of the thinking process as to its logic and coherence (e.g. perseveration, tangentiality and circumstantiality)</td>
</tr>
<tr>
<td>Content – ideas that are present in the thinking process (e.g. delusions, overvalued ideas and somatization)</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Score (ICF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sequencing and coordinating complex, purposeful movement (e.g. oculomotor and speech apraxia)</td>
</tr>
</tbody>
</table>

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.

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

Use the ICF Rating Scale unless otherwise instructed:

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

<table>
<thead>
<tr>
<th>Score (ICF)</th>
<th>Control – speed of behavior or response time that involves both motor and psychological components</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quality – non-verbal behavior e.g. hand-eye coordination</td>
</tr>
</tbody>
</table>

### Activity Limitations & Participation Restrictions

<table>
<thead>
<tr>
<th>Score (ICF)</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Undertaking Multiple Tasks – carrying out simple or complex and coordinated actions as components of multiple, integrated and complex tasks in a sequence or simultaneously.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Life Role – cognitive abilities necessary for success in the individual’s community, school and/or work environments and life role (homemaker, parent, worker, student)</td>
</tr>
</tbody>
</table>

Use the ICF Rating Scale unless otherwise instructed:

- 0 = No Impairment (0-4%)
- 1 = Mild Impairment (5-24%)
- 2 = Moderate Impairment (25-49%)
- 3 = Severe Impairment (50-95%)
- 4 = Complete Impairment (96-100%)
- 8 = Not specified
- 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
- □ Larynectomy
- □ Missing Teeth
- □ Dentures
- □ Facial Paralysis
- □ Other oral structure malformations (specify)

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

Receptive Language

Expressive Language

Activity Limitations

<table>
<thead>
<tr>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving Spoken Messages – comprehending literal and implied meanings of messages</td>
</tr>
<tr>
<td>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)</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Score (ICF)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Communication Devices – Writing – using machines for writing such as typewriters, computers, or Braille writers as a means of communication</td>
</tr>
<tr>
<td></td>
<td>Communication Devices – Speaking – using an alternative/augmentative communication device for expressing wants and needs.</td>
</tr>
</tbody>
</table>

### Participation Restrictions

<table>
<thead>
<tr>
<th>Score (ICF)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

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- 1 = Mild Impairment (5-24%)
- 2 = Moderate Impairment (25-49%)
- 3 = Severe Impairment (50-95%)
- 4 = Complete Impairment (96-100%)
- 8 = Not specified
- 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

<table>
<thead>
<tr>
<th>Score (ICF)</th>
<th>Impairments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Upper Extremity Range of Motion How score?</td>
</tr>
<tr>
<td></td>
<td>Upper Extremity – Gross Motor Strength How score?</td>
</tr>
<tr>
<td></td>
<td>Upper Extremity – Fine Motor Strength, including grasp and pinch How score?</td>
</tr>
<tr>
<td></td>
<td>Trunk Control How score?</td>
</tr>
<tr>
<td></td>
<td>Sitting Balance – ability to maintain sitting on the side of the bed without support</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>Sensory deficits as barriers to self-care</td>
</tr>
<tr>
<td></td>
<td>Cognitive deficits as barriers to self-care</td>
</tr>
</tbody>
</table>

Activity Limitations & Participation Restrictions

<table>
<thead>
<tr>
<th>Score (ICF)</th>
<th>Activity Limitations &amp; Participation Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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)</td>
</tr>
<tr>
<td></td>
<td>Upper Body Dressing</td>
</tr>
<tr>
<td></td>
<td>Lower Body Dressing</td>
</tr>
<tr>
<td></td>
<td>Tub/Shower Transfers – ability to safely get in/out of tub or shower</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

Use the ICF Rating Scale unless otherwise instructed:

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

<table>
<thead>
<tr>
<th>Score (ICF)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Cleaning Cooking Area &amp; Utensils – Cleaning up after cooking, such as by washing dishes, pans, pots and cooking utensils, and cleaning tables and floors around the cooking area.</td>
<td></td>
</tr>
<tr>
<td>Cleaning Living Area – Such as tidying and dusting, sweeping, mopping floors, cleaning bathrooms and toilets, and other household furnishings.</td>
<td></td>
</tr>
<tr>
<td>Using Household Appliances – Such as washing machines, driers, irons, vacuum cleaner and dishwashers.</td>
<td></td>
</tr>
<tr>
<td>Maintaining Dwelling &amp; 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.</td>
<td></td>
</tr>
<tr>
<td>Maintaining Vehicles – Repairing and taking care of motorized vehicles, such as automobiles</td>
<td></td>
</tr>
<tr>
<td>Maintaining DME, including wheelchairs, or directing a caregiver to do so</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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).</td>
<td></td>
</tr>
<tr>
<td>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.)</td>
<td></td>
</tr>
</tbody>
</table>

**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) ____________________________________________________________________

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- 2 = Moderate Impairment (25-49%)
- 3 = Severe Impairment (50-95%)
- 4 = Complete Impairment (96-100%)
- 8 = Not specified
- 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

<table>
<thead>
<tr>
<th>Score (ICF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower Extremity Range of Motion  How score?</td>
</tr>
<tr>
<td>Lower Extremity – Gross Motor Strength How score?</td>
</tr>
<tr>
<td>Trunk Strength &amp; Control  How score?</td>
</tr>
<tr>
<td>Standing Balance – ability to maintain standing without support</td>
</tr>
<tr>
<td>Lower Extremity Motor Control &amp; 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)</td>
</tr>
<tr>
<td>Sensory deficits as barriers to locomotion</td>
</tr>
<tr>
<td>Cognitive deficits as barriers to locomotion</td>
</tr>
</tbody>
</table>

Activity Limitations & Participation Restrictions

<table>
<thead>
<tr>
<th>Score (ICF)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rolling – moving from one lying position to another on the same level</td>
</tr>
<tr>
<td>Lying Down – getting into and out of a lying down position or changing body position from horizontal to sitting, or sitting to lying down.</td>
</tr>
<tr>
<td>Sit to/from Stand – getting into and out of a seated position and changing body position from sitting to standing or standing to sitting.</td>
</tr>
<tr>
<td>Bending – Tilting the back downwards or to the side, at the torso, such as bowing or reaching down for an object on the floor.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Score (ICF)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Household Ambulation – walking ≤ 150 feet such as walking around rooms or hallways, within a building, or for short distances outside</td>
<td></td>
</tr>
<tr>
<td>Community Ambulation – walking ≥150 feet such as walking blocks, doing shopping, or in the school or work place</td>
<td></td>
</tr>
<tr>
<td>Walking on different surfaces – ability to walk on sloping or uneven surfaces such as on grass, gravel, ice or snow.</td>
<td></td>
</tr>
<tr>
<td>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 crowded areas.</td>
<td></td>
</tr>
<tr>
<td>Crawling – moving the whole body in a prone position from one place to another on hands, or hands and arms, and knees.</td>
<td></td>
</tr>
<tr>
<td>Climbing – Moving the whole body upwards or downwards, over surfaces or objects, such as climbing steps, ladders or stairs, curbs or other objects.</td>
<td></td>
</tr>
<tr>
<td>Running – Moving with quick steps so that both feet may be simultaneously off the ground.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Community Wheelchair Propulsion – propelling a manual or power wheelchair ≥150 feet such as propelling blocks, doing shopping, or in the school or workplace.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

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- 8 = Not specified
- 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

<table>
<thead>
<tr>
<th>Score (ICF)</th>
<th>Appropriateness of Emotion – Mental functions that produce congruence of feeling or affect with the situation, such as happiness at receiving good news.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regulation of Emotion – Mental functions that control the experience and display of affect. (e.g. lability)</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

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:

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### Activity Limitations & Participation Restrictions

<table>
<thead>
<tr>
<th>Score (ICF)</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Interpersonal Interactions</strong> – 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)</td>
<td></td>
</tr>
<tr>
<td><strong>Relationships</strong> – beginning, maintaining and ending relationship interactions with others in a contextually and socially appropriate manner</td>
<td></td>
</tr>
<tr>
<td><strong>Regulating Behaviors within Interactions</strong> – Regulating emotions and impulses, verbal and/or physical aggression in interactions with others, in a contextually and socially appropriate manner.</td>
<td></td>
</tr>
<tr>
<td><strong>Parent-Child Relationships</strong> – Being a parent, providing physical, intellectual and emotional nurture to one’s natural or adoptive child.</td>
<td></td>
</tr>
<tr>
<td><strong>Child-Parent Relationships</strong> – 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.</td>
<td></td>
</tr>
<tr>
<td><strong>Sibling Relationships</strong> – Creating and maintaining a brotherly or sisterly relationship with a person who shares one or both parents by birth, adoption or marriage.</td>
<td></td>
</tr>
<tr>
<td><strong>Intimate Relationships</strong> – Creating and maintaining close or romantic relationships between individuals, such as husband and wife, lovers, or sexual partners.</td>
<td></td>
</tr>
<tr>
<td><strong>Handling Stress and other Psychological Demands</strong> – 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.</td>
<td></td>
</tr>
<tr>
<td><strong>Employability (FAM)</strong> – 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.</td>
<td></td>
</tr>
<tr>
<td><strong>Community Life</strong> – Engaging in all aspects of community social life, such as engaging in charitable organizations, service clubs or professional or social organizations.</td>
<td></td>
</tr>
<tr>
<td><strong>Recreation &amp; Leisure</strong> – Engaging in any form of play, recreational, or leisure activity, such as informal or organized play and sports, relaxation, amusement.</td>
<td></td>
</tr>
<tr>
<td><strong>Religion &amp; Spirituality</strong> – Engaging in religious or spiritual activities, organizations and practices for self-fulfillment, finding meaning, establishing connection with a divine power.</td>
<td></td>
</tr>
</tbody>
</table>

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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.

<table>
<thead>
<tr>
<th>Score (above)</th>
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<tbody>
<tr>
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<td>4 = Complete (96-100%)</td>
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<td>1 = Mild (5-24%)</td>
<td>8 = Not specified</td>
</tr>
<tr>
<td>2 = Moderate (25-49%)</td>
<td>9 = Not Applicable</td>
</tr>
<tr>
<td>3 = Severe or Substantial (50-95%)</td>
<td></td>
</tr>
</tbody>
</table>

| 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. |