The Future of Medical Rehabilitation and Other Post Acute Care Hospital Providers: The Continuing Care Hospital

American’s health care system needs a new approach to delivering and financing medical rehabilitation services provided by today’s inpatient institutional providers: inpatient rehabilitation hospitals and units (IRH/Us), hospital-based skilled nursing facilities (HSNFs) and long term care hospitals (LTCHs). The American Medical Rehabilitation Providers Association (AMRPA) proposed the creation of a Continuing Care Hospital (CCH) that would organize care around the patient instead of the facility. A key feature of the CCH is that it would enhance quality of care by eliminating boundaries among these current hospital-based post-acute care (PAC) providers and implement common quality standards, outcome measures, and accountability. It would result in reduced costs to deliver the care and also improve the cost benefit and cost effectiveness of those services.

The Affordable Care Act (ACA) requires that the Department of Health and Human Services (HHS) implement a Continuing Care Hospital (CCH) model that will reform the way in which post acute care is delivered.\(^1\) However, to date, HHS has not made progress in implementing the CCH model.

**Questions and Answers**

1. **Is the CCH concept a stand-alone concept or an alternative to bundling?**
   The CCH model provides an alternative to some of the bundling concepts being discussed, such as bundling all acute and post acute care. The CCH model, instead focuses on the post acute care hospital continuum.

2. **What is the entity that is accountable for and accepts the risk?**
   The CCH accepts the risk for the patient’s post acute care (medical and rehabilitation) for the entire CCH stay and 30 days after discharge from the CCH. In return for accepting that financial risk, the CCH has the freedom to place the patient in the specific level of care that is clinically appropriate and best matches the resources available to the patient’s need. This allows improved efficiencies and lower overall operating costs for the CCH.

3. **How are care coordination/transition of care addressed?**
   The CCH would work closely with the acute care hospitals in its market (or other referral sources) to provide as seamless a transition as possible to assure proper placements and prevent unneeded hospital readmissions. In addition, the CCH may use the Continuity

\(^{1}\) 42 U.S.C. 1395cc-4 (authorized the Continuing Care Hospital model as a bundling pilot) and 42 U.S.C. 1315a allows the Department of Health and Human Services Secretary to test the Continuing Care Hospital model through the Center for Medicare and Medicaid Innovation (CMMI)
Assessment Record and Evaluation (CARE) tool as an assessment tool for patients. CMS has included the use of the CARE tool in the 9th Scope of Work for the Quality Improvement Organizations (QIOs) and as the assessment tool for the Care Transition Project announced on April 13, 2011.

4. Will the CCH save the Medicare program money?
The first goal of any health care delivery system reform should be to assure access to and provide high quality care. We believe that the CCH concept meets that goal. In addition, streamlining transitions between levels of care will save funds and reduce readmissions to acute care. Eliminating unnecessary federal regulations such as the IRF PPS, LTCH PPS, and the SNF PPS will accomplish the same goal. It may also require amending the 25% rule for LTCHs, 60% rule for IRFs, one day rule for LTCHs and IRFs, and 3 day and 30 day rule for HSNFs. Other standards focused on clinical care and quality, including outcome and performance measures, would be established.

5. What is the Episode of Care?
The episode of care is the stay in the CCH plus the first 30 days post-CCH discharge. Subsequent health care costs after discharge from the CCH resulting from clearly unrelated events or illnesses (for example, a patient discharged to home subsequently experiences burns in a car fire and requires care for a new illness or injury) would be carved out from the CCH’s accountability. Hence, when the CCH determines that the patient is ready to be discharged, it would contract with another provider such as a home health agency, freestanding skilled nursing facility (FSNF), or outpatient provider for the services and coordinate the discharge and follow up for 30 days.

6. How is payment determined per episode?
Payment would be based on a patient classification system of Continuing Care Hospital Care Groups (CCHCGs). These would be devised from data from the various settings and cover a number of domains. The data could be derived from the CARE tool. Data should also utilize the ICD-10s and ICF nomenclature. The initial patient classification system would be further analyzed with cost reports, claims, Medicare Provider Analysis and Review (MEDPAR), and other information to develop weights and a standard payment amount.

7. Are there any adjustments to this one per episode CCHCG payment?
Yes, as with current payment systems, the Centers for Medicare and Medicaid Services will need to make adjustments for geographical differences and specific adjustments for the level of care. For example, depending on the structure of the data, there may also be special payment policies such as transfers, outliers, etc.

8. How will health information technology (HIT) be used in the CCH concept?
Enhanced coordination of patient care is a key goal of this approach. In order to achieve that goal, the CCH will need to utilize electronic medical records, or transition to them, throughout the system, be it real or virtual. These records will also need to be coordinated with the acute hospitals. Ideally, federal economic incentives would be
provided to nurture the development of cross-facility electronic health record systems to accelerate the savings and care enhancement.

9. Will there be any changes to federal regulations and statutes? What about state regulations?
   We anticipate that several sets of regulations need to be examined and either amended or deleted. These would include those mentioned above such as the separate payment systems for the current entities, exclusion criteria for IRH/Us and LTCHs, and medical necessity criteria, among others. State regulations may also need to be amended, because the CCH would require state licensure as a hospital (of any sort). SNF licensure and HSNF regulations would also likely need to be examined. Virtual CCHs that form may face certificate of need (CON) and licensure barriers in some states that will also need to be addressed.

10. If so many statutes and regulations must be changed in the implementation of a real CCH, what will be done to assure that the government is purchasing the kind and quality of care it expects in lieu of the current model of just paying?
    The creation and availability of outcomes data from the CCH is one of the major benefits of this delivery system reform. Information will be available to monitor facility function both medically and with regard to increased quality of life. It will measure discharge destination, changes in functional status, mortality, unplanned readmissions to acute care, and acquired conditions. The CCH would be held accountable for these outcomes and payment incentives would need to be established to recognize them.

11. What type of implementation for the CCH model should be followed?
    The initial pilot project, as authorized by the ACA, should be conducted by the Center for Medicare and Medicaid Innovation (CMMI, or the Innovation Center) to study the model. Once demonstrated to be effective, statutory changes would be required, federal rules and regulations should be promulgated, and model state law and regulation revision guidance documents should be developed to assist each state to enable this new model of health care delivery.

    In addition, no change in payment should be made for two years so that providers have adequate experience and data from which to develop baselines for outcomes. This means that the CCHCG payments would not be reduced. At the same time, pre-CCH outcomes information for the three entities should be retained to the extent it exists. After two years, incentive payments would include reductions in payment for failure to report certain information and/or meet specified outcomes standards. Incentive payments would also include increases in payment for exceeding certain outcomes standards. The overall objective would be to assure that final payment aligns patient, payer, and provider needs.

12. Why are freestanding SNFs excluded from the CCH concept?
    Freestanding SNFs would be eligible to participate if they met the same standards, requirements, and outcomes that all other components of the CCH model would be required to meet, be it real or virtual.
13. Can an existing single-level provider (an LTCH, IRF, or SNF) participate in the CCH payment system?
Yes. The fundamental premise of the CCH as a clinical operation is that there is a well-defined (by regulation) level of services offered at each of the three program levels (e.g., specifications for intensity, frequency, and provider qualifications, as well as coordination and goal direction). If a single-level provider wants to participate in the CCH service model, it will need to provide services at the level specified, to the types of patients who are eligible to receive that level of service. In addition, it will need to capture and be accountable for the outcome data that are specified, and accept the predetermined payment (generally equivalent to the full CCH payment). This single-level provider would be financially at risk for all the health care costs of the patient for the duration of the admission as well as the 30-day follow-on period.

14. What happens if a patient needs home health or FSNF care during the episode of care?
The home health agency (HHA) or FSNF could contract with the CCH to provide care and those costs would be accounted for in the original design of the CCHCG payments.

15. What would happen to a patient who required home health services or was discharged to a freestanding SNF directly from acute care?
The HHA and FSNF would continue to be paid based on the current payment systems, or any alternative system devised such as an acute-HHA-SNF bundle.

16. How would the system account for patients who are transferred back to the acute care hospital? How would the cost of care be addressed?
The pilot needs to consider several approaches. These include a “transfer rule” that cuts the CCH payment short; a shared responsibility model in which both the referring hospital and the CCH share financial responsibility for rehospitalization within 30 days of the acute care stay; or an examination of the type of readmission—was it a preventable readmission by virtue of the acute hospital discharging the patient too soon (and the CCH would not have to pay); was it a planned readmission at the time of discharge from the acute hospital; was it completely unforeseen and the patient had a new medical condition or acute change in the current condition?

17. How will services be paid for after the end of the episode of care? For example, patients sometimes require home health care beyond 30 days; or a patient may be admitted to and remain in a SNF over 30 days and still be qualified for Medicare.
The pilot program, in modeling the original episodes, should address the incidence of the length of this type of care post current IRF, LTCH or HSNF care. Having done so, it might consider additional payments under the current payment systems (if retained) to the HHAs and the SNFs on a per diem basis.