U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

COST AND RESOURCE UTILIZATION (CRU) DATA COLLECTION FOR THE MEDICARE POST ACUTE CARE PAYMENT REFORM DEMONSTRATION

OFFICE OF MANAGEMENT AND BUDGET CLEARANCE PACKAGE SUPPORTING STATEMENT-PART A

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Supporting Statement Part A for Administering the Cost and Resource Utilization (CRU) Data Collection for the Medicare Post Acute Care Payment Reform Demonstration

A. BACKGROUND

The Cost and Resource Utilization (CRU) data collection is part of the Post-Acute Care Payment Reform Demonstration mandated by Section 5008 of the Deficit Reduction Act of 2005. This demonstration is intended to address problems with the current Medicare payment systems for post-acute care services, including those for Long Term Care Hospitals (LTCHs), Inpatient Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs). Each of these four types of providers currently has a separate prospective payment system (PPS) with its own case-mix groups, payment units, and rates. Each case-mix grouper uses a unique set of items to measure patients, making it difficult to compare severity, costs, and outcomes across settings. These four provider types form a continuum of care where patients may overlap in terms of the conditions being treated, but they primarily differ in terms of the severity of the patients' medical or functional impairments. The current payment methods are designed as silos that do not recognize the potential overlap in case mix or the complimentary nature of the services across an episode, nor does it allow for standardized measures of costs across settings since each PPS was developed independently using different measurement systems and underlying assumptions.

The Post-Acute Care Payment Reform Demonstration will examine the relative costliness and outcomes of post acute cases admitted to different settings for similar conditions. The work will differ from past attempts in this area because it will use a standardized case mix tool for measuring patient severity and a standardized resource data collection tool in all four post acute settings. Specifically, the legislation requires that the Centers for Medicare and Medicaid Services (CMS) provide information on both the fixed and variables costs for each individual treated in post acute care settings. CMS awarded contracts for both the uniform patient assessment development, the Continuity Assessment Record and Evaluation (CARE), and for the payment reform demonstration to RTI, International (RTI). During the demonstration, data will be collected in 10 geographically diverse markets and will include 150 providers. The providers will include short stay acute hospitals which will provide standardized information on patient severity at discharge; and the four post acute settings which will submit patient severity information at admission and discharge and cost and resource use data that will identify the level and types of services provided in each setting. Note that of the 15 acute providers expected to participate in the demonstration, only 3 acute providers will collect CRU data in addition to CARE data. The data will be used, along with Medicare claims and cost report data, to examine substitution issues: how do costs and outcomes differ for post acute care patients with similar case mix acuity when treated in one of the various settings? The results will be used to provide CMS and Congress information on setting-neutral payment models, revisions to single setting payment systems, current discharge placement patterns, and patient outcomes across settings.

The CRU data collection instruments are designed to collect a provider's routine costs to specific patients because in general, nurses' and many other direct care providers' time spent on behalf of specific patients and on activities not patient-specific, is not reported. In addition, charges for therapist services reported on claims may not sufficiently measure true relative

differences in therapy resource costs among patients. To collect these data, we will use data collection instruments to be completed by each staff person engaged in direct patient care in the participating facilities. The CRU tools will consist of six separate forms: (1) the CRU Non-Therapist Staff Activity Form, collecting time staff spend with each patient in participating institutional providers (SNF, LTCH, IRF, Acute); (2) the CRU Therapy Staff Activity Form, collecting time therapy staff spend with each patient in participating institutional providers (SNF, LTCH, IRF, Acute); (3) the Home Health Patient Time Log, collecting time staff spend with each patient in the home health setting (HHA); (4) the CRU Patient Ancillary Service Log Form, collecting data on the type and receipt date of certain costly ancillary services for each patient in institutional providers (SNF, LTCH, IRF, Acute); (5) the Consultant Log Form, collecting data on the time that off-unit clinicians spend with study patients and date of service (SNF, LTCH, IRF, Acute); and (6) the Patient Tracking Form which is a crosswalk of study IDs to Medicare numbers to better preserve patient confidentiality (all providers).

In addition to each of the six data collection instruments, we have developed interview protocols which will be fielded in each of the providers recruited to participate in the demonstration. For providers collecting CRU data, CMS and RTI will interview each provider's chief financial officer, a senior administrator, the therapy manager, and the nurse manager. For the acute providers not collecting CRU data, CMS will interview a senior administrator and the nurse manager. The purpose of these interviews is to give context to the data collection effort. It will be critical to understand the staffing patterns in each provider, staffing costs, ancillary service use, and general background information on each provider and the market they operate in.

A brief description of each of the CRU data collection instruments and interview protocols is outlined below. Each of the CRU data collection instruments, interview protocols, and training materials is included in the Appendices of this report.

CRU Forms

1. *CRU (Non-Therapist) Staff Activity Form*

The CRU (Non-Therapist) Staff Activity Form is a one-page paper form which will record time that staff spend with or on behalf of specific patients, in activities related to patient care and on administrative duties for institutional providers only. Each form will be specific to an individual staff person on a specific date and will be used to identify the caregiver's role and report time with each patient during a shift. Staff time will be allocated to five types of activities specified on the form: administering medication; providing personal care or nursing interventions; charting and treatment planning; transporting patients to off-unit locations; administrative or other non-patient-specific activities. This form will be filled out by all non-therapy staff.

2. *CRU Therapy Staff Activity Form*

The CRU Therapy Staff Activity Form is a one-page paper form which will record time that therapy staff spend with or on behalf of specific patients, in activities related to patient care and on administrative duties for institutional providers only. Each form will be specific to an

individual staff person on a specific date and will be used to identify the therapist's role and report time with each patient during a shift. Staff time will be allocated to group therapy, individual therapy, and other activities including administrative duties, charting, care planning, and breaks. Therapists will also record the amount of time that each patient spends in group therapy sessions.

3. *Home Health Patient Time Log*

The Home Health Patient Time Log is a one-page form which will record time that staff spend with or on behalf of specific home health patients, in activities related to patient care and on administrative duties. Each form will be specific to an individual staff person on a specific date and will be used to identify the caregiver's role and report time with each patient during a shift.

4. *CRU Patient Ancillary Service Log*

The CRU Ancillary Service Log form is a one-page instrument which will record when patients receive certain high-cost ancillary services on a particular date. In hospital settings there may be no bill for the services bundled into the Part A services. Each CRU-Log sheet will be specific to a particular calendar day. The Site Coordinator at each participating provider will keep the CRU Ancillary Service Log forms at a central location in each participating unit (e.g., the nurse's station). The Site Coordinator and the administrative staff at the nurses' station will be responsible for monitoring the Ancillary Service Log.

5. *CRU Non-Physician Consultant Log Form*

The CRU Non-Physician Consultant Log Form is a one-page instrument which will record the time that consultants, or other staff not specifically assigned to the unit, spend with, or on behalf of patients on the unit. Examples of clinicians that may provide consultations are listed across the top of the form and include therapists, nutritionists, wound care nurses, discharge planners, and social workers. Each sheet will log activity for a particular day. The Site Coordinator at each participating provider will keep the CRU Non-Physician Consultant Log forms at a central location in each participating unit (e.g., the nurse's station). The Site Coordinator and the administrative staff at the nurses' station will be responsible for monitoring the Non-Physician Consultant Log form.

6. *CRU Patient Tracking Form*

The CRU Patient Tracking Form records the Medicare Health Insurance Claim (HIC) number, necessary for merging with claims data, for all Medicare patients in the study. The facility's site coordinator will maintain this form and will redact patient names prior to submitting the forms to RTI and CMS.

Interview Protocols

We have developed eight interview protocols in order to learn more about the characteristics of individual providers participating in the demonstration and their patient populations. These interviews target three types of provider staff in providers collecting CRU data: nurse and

therapy managers; administrators; and financial officers. In the acute providers not collecting CRU data, we will only interview an administrator and the nurse manager. We have developed separate interview protocols for institutional providers collecting CRU data, acute providers not collecting CRU data, and home health providers due to important differences in organizational structure. Examples of items included in the interview protocols are outlined below.

1. *Nursing and Therapy Management Interview Protocol*

    - Number of beds on the unit, average daily census, average length of stay, types of patients treated;
    - Staffing patterns;
    - Use of patient acuity and/or functional scoring systems;
    - Use of ancillary services;

2. *Facility Administration Interview Protocol*

    - Provider mission and niche in local market;
    - Organizational structure of provider;
    - Provider referral patterns;

3. *Financial Interview Protocol/Information Request*

    - Reports of ancillary services provided to patients in last six months;
    - Identification of fixed versus variable costs in the cost accounting system;
    - Cost reporting procedures;
    - Average hourly wages and staffing;

JUSTIFICATION

A.1 Need and Legal Basis

In order to meet the requirements of Section 5008 of the Deficit Reduction Act (See Appendix J), CMS must collect information on the fixed and variable costs for beneficiaries receiving post-acute care services at the participating demonstration sites. This information is not collected as part of standard Medicare operations and therefore it is necessary to field the CRU data collection instruments to document the staff time and ancillary services associated with caring for beneficiaries in post-acute care settings. It will also be necessary to interview key staff members including the therapy manager, nurse manager, administrator, and chief financial officer at each demonstration site in order to understand the staffing patterns and the structure of each unit at each participating provider.

This information will be collected as part of the Post-Acute Care (PAC) Payment Demonstration mandated to begin January 2008.The purpose of the demonstration is to collect data that will enable CMS to better understand the relationships among patient needs, post-acute care placement, patient outcomes, and post-acute care costs and resource use in the Medicare program. The demonstration also includes the Continuity Assessment Record and Evaluation (CARE) instrument data collection (included in a separate OMB clearance package) which will be combined with cost and resource utilization data and Medicare claims data to develop a post-acute care payment reform model. CMS will deliver a Report to Congress on the demonstration including results and recommendations for legislation and administrative action as the Secretary determines to be appropriate.

A.2 Information Users

The data collected using the CRU instruments and staff interview protocols during the Post-Acute Care Payment Demonstration will be used by CMS to develop a setting neutral post-acute care payment model as mandated by Congress. The data will be used in conjunction with data collected in the CARE instrument to characterize patient severity of illness and level of function in order to predict resource use, post-acute care discharge placement, and beneficiary outcomes. CMS will use the data from the CRU and the CARE instruments to examine the degree to which it is possible to predict beneficiary resource use and outcomes based on patient severity of illness.

A.3 Use of Information Technology

The CRU data will be collected using paper forms which will be scanned into an electronic database using scanning software configured to meet the requirements of this data collection. The data collection is paper-based rather than electronic for the convenience of clinicians. Each clinician treating patients in participating hospitals will have one Staff Activity Form per per day of data collection where they will record their time. A broad range of staff will be tracking time including nurses, nurses aides, therapists, pharmacists, social workers, and managers among other. These staff may not have ready access to computers for recording time electronically. Each staff member will be responsible for filling in their time as is convenient throughout their shift. The ancillary and consultant logs are also paper-based for ease of use. The forms will be stored at a central location such as the nurses' station to ensure easy access for clinicians coming onto the units.

A.4 Duplication of Efforts

This data collection does not duplicate any other effort and the information cannot be obtained from any other source. Existing administrative data sources cannot be used to allocate a provider's routine costs to specific patients because in general, nurses' and many other direct care providers' time spent on behalf of specific patients and on activities not patient-specific, is not reported. In addition, charges for therapist services reported on claims may not sufficiently measure true relative differences in therapy resource costs among patients. Congress has mandated that CMS provide information on the fixed and variable costs for each individual in post-acute care settings in the Post-Acute Care Payment Reform Demonstration. The CRU data collection effort is a unique opportunity to document the types of staff treating individual patients and the types of activities that they perform.

A.5 Small Businesses

Providers participating in the Post-Acute Care Payment Reform Demonstration will potentially include small home health agencies and skilled nursing facilities as well as larger hospitals and other post-acute providers. Provider participation in the demonstration is voluntary. Small providers viewing the data collection as a burden can refuse to participate.

A.6 Less Frequent Collection

This is a one-time data collection effort limited to the three-year study period of the Post-Acute Care Payment Reform Demonstration as mandated by Congress under Section 5008 of the Deficit Reduction Act of 2005. Data collection will be limited to providers volunteering to participate in the demonstration.

A.7 Special Circumstances

The CRU data collection will be conducted for three two-week periods in each of the participating providers in the Post-Acute Care Payment Reform Demonstration. Data coordinators at participating demonstration providers will review data for completeness prior to submission to CMS. Data will be reported to CMS at the conclusion of each two-week data collection period.

A.8 Federal Register/Outside Consultation

The 60-day Federal Register notice published on August 24, 2007.

CMS developed the CRU data collection instruments and the interview protocols in consultation with clinicians practicing in long term care hospitals, skilled nursing facilities, inpatient rehabilitation facilities, and home health agencies. Limited pre-testing of the data collection instruments included soliciting feedback from a range of clinical staff.

Following the publication of the Federal Register Notice, CMS will review and incorporate additional comments and feedback from the public.

Members of the CRU data collection instrument and interview protocol development team outside of CMS include:

- Barbara Gage, RTI International
- Melvin Ingber, RTI International
- Edward Drozd, RTI International
- Roberta Constantine, RTI International
- Christopher Murtaugh, Visiting Nurse Service of New York

A.9 Payment/Gifts to Respondents

There will be no payments/gifts to respondents to the CRU data collection instrument or staff interviews.

A.10 Confidentiality

The data collected in the CRU data collection instrument will be kept confidential by RTI and CMS. Only authorized staff at participating demonstration providers and project staff at CMS and RTI will have access to the data. To protect beneficiary confidentiality, the subject's name will not be linked to his/her individual data. For identification purposes, a unique ID number will be assigned to each sample member. All patient names on the Staff Activity Forms will be redacted by each demonstration site data coordinator prior to submission to CMS and RTI. Data will be stored in a secure format meeting all federal privacy guidelines.

Responses to the staff interviews will also be kept confidential and will be used solely for the purpose of background for understanding each participating provider's internal processes as they related to distinguishing between fixed and variable costs.

A.11 Sensitive Questions

Information collected in this survey is not of a sensitive nature. Items on the CRU data collection instruments are limited to recording time spent with patients and the questions on the interview protocols for provider staff are limited to understanding operational issues.

A.12 Burden Estimates (Hours & Wages)

CMS estimates that the average time to complete the CRU instrument is 15 minutes. CRU data collection will occur in for three two-week periods in each of the 138 participating post-acute providers during the nine-month data collection period. CRU data collection will occur in 3 acute hospitals specialty units, 11 LTCHs, 18 IRFs, 48 SNFs, and 48 HHAs.

Table A-1 shows the estimated data collection burden for the staff activity logs and home health patient time logs by type of participating provider as calculated using the expected number of CRU patient days/visits per provider. The total burden estimate for this portion of the data collection is estimated to be 15,361 hours.

In addition to collecting staff time, the site coordination activities related to the overseeing the data collection, the ancillary log, and the consultant log impose additional burden

to participating providers. This burden, as well as the burden of the interviews in the participating providers, are shown in Table A-2. We estimate that site coordination activities will be approximately 90 hours of effort over the three two-week CRU data collection periods and that the interviews in providers participating in the CRU data collection will take approximately 7 hours total including the background work that respondents will need to complete prior to the interviews. We will also conduct two interviews in acute providers not collecting CRU data and we estimate these interviews to take 3 hours per provider. The total burden estimate for this portion of the data collection is estimated to be 13,422 hours.

Table A-1. CRU-SAF/HHL Burden Estimate

Provider Type	Target Number of Participating Providers	Expected Number of CRU Patient Days/Visits	Average CRU-SAFs/ CRU-HHLs per Patient Day/Visit	Total Number of CRU-SAFs/ CRU-HHLs	Total Estimated Burden (Hours)
Acute Hospitals	15[1]	2,659	1.746	4,643	1,161
LTCH	11	9,750	1.746	17,023	4,256
IRF (Freestanding)	7	3,803	1.465	5,571	1,393
IRF (Hospital Unit)	21	5,947	1.465	8,712	2,178
SNF (Freestanding)	42	15,525	1.191	18,490	4,622
SNF (Hospital-Based)	6	1,725	1.191	2,054	514
HHA (Freestanding)	39	24,974	0.167	4,171	1043
HHA (Hospital-Based)	9	4,639	0.167	775	194
Total	150	69,022	…	61,439	15,361

Table A-2. Additional Data Collection Burden

Provider Type	Target Number of Participating Providers	Expected CRU Site Coordinator Burden per Provider (Hours)	Expected Interview Burden per Provider (Hours)	Total Estimated Burden (Hours)
Acute Hospitals not collecting CRU[1]	12	…	3.00	36.00
Acute Hospitals collecting CRU[1]	3	90.00	7.00	291
LTCH	11	90.00	7.00	1,067
IRF (Freestanding)	7	90.00	7.00	679
IRF (Hospital Unit)	21	90.00	7.00	2,037
SNF (Freestanding)	42	90.00	7.00	4,074
SNF (Hospital-Based)	6	90.00	7.00	582
HHA (Freestanding)	39	90.00	7.00	3,783
HHA (Hospital-Based)	9	90.00	7.00	873
Total	150			13,422

Note:
1. CRU data collection will occur in up to three specialized subunits of acute hospitals. CRU data collection will not occur in the other 12 participating acute providers.

Since the August submission, CMS and RTI have made minor changes to the CRU instrument in response to public comments and internal review. The changes are primarily wording changes and direction clarifications. These changes are not expected to impact the data collection burden.

A.13 Capital Costs

There are no additional capital costs to respondents or to record keepers.

A.14 Cost to Federal Government

There is not additional cost burden to the federal government beyond what Congress has allocated for the demonstration.

A.15 Changes to Burden

There are no program changes or adjustments.

A.16 Publication/Tabulation Dates

There are no publications and tabulations associated with this collection.

A.17 Expiration Date

The OMB expiration date will be displayed on all disseminated data collection materials.

A.18 Certification Statement

There are no exceptions to the certifications statement.

APPENDIX A
CRU UNIT (NON-THERAPIST) STAFF ACTIVITY FORM

APPENDIX B
CRU THERAPY STAFF ACTIVITY FORM

APPENDIX C
HOME HEALTH PATIENT TIME LOG

APPENDIX D
CRU PATIENT ANCILLARY SERVICE LOG

APPENDIX E
CRU NON-PHYSICIAN CONSULTANT LOG FORM

APPENDIX F
CRU PATIENT TRACKING FORM

APPENDIX G
NURSING AND THERAPY MANAGEMENT INTERVIEW PROTOCOLS

APPENDIX H
FACILITY ADMINISTRATION INTERVIEW PROTOCOLS

APPENDIX I
FINANCIAL INTERVIEW PROTOCOLS

APPENDIX J
DEFICIT REDUCTION ACT SECTION 5008

SEC. 5008. POST-ACUTE CARE PAYMENT REFORM DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.— (1) IN GENERAL.—By not later than January 1, 2008, the Secretary of Health and Human Services (in this section referred to as the ‘‘Secretary’’) shall establish a demonstration program for purposes of understanding costs and outcomes across different post-acute care sites. Under such program, with respect to diagnoses specified by the Secretary, an individual who receives treatment from a provider for such a diagnosis shall receive a single comprehensive assessment on the date of discharge from a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) of the needs of the patient and the clinical characteristics of the diagnosis to determine the appropriate placement of such patient in a post-acute care site. The Secretary shall use a standardized patient assessment instrument across all post-acute care sites to measure functional status and other factors during the treatment and at discharge from each provider. Participants in the program shall provide information on the fixed and variable costs for each individual. An additional comprehensive assessment shall be provided at the end of the episode of care. (2) NUMBER OF SITES.—The Secretary shall conduct the demonstration program under this section with sufficient numbers to determine statistically reliable results. (3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 3-year period. (b) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 42 U.S.C. 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section. (c) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, that includes the results of the program and recommendations for such legislation and administrative action as the Secretary determines to be appropriate. (d) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i), $6,000,000 for the costs of carrying out the demonstration program under this section.

APPENDIX K
CRU TRAINING MATERIALS