

The Improving Medicare Post-Acute Care Transformation Act of 2014 “IMPACT Act of 2014 ”

Section-By-Section

Section 1: Short Title

Section 2: Standardization of Post-Acute Data

Requirement for Standardized Assessment Data. Amends title XVIII of the Social Security Act (SSA) to add a new section 1899B. Requires post-acute care (PAC) and other providers to report standardized patient assessment data and requires PAC providers to report standardized quality measures and resource use measures. Requires the Secretary to modify PAC assessment instruments to allow for submission of standardized patient assessment data and to allow for comparison of such data across all such providers.

Definition of PAC Providers. Defines PAC Providers as: 1) home health agencies (HHA); 2) skilled nursing facilities (SNF); 3) inpatient rehabilitation facilities (IRF); and 4) long-term care hospitals (LTCH).

Definition of PAC Assessment Instruments. Defines PAC assessment instruments as: 1) Outcome and Assessment Information Set (OASIS); 2) the Minimum Data Set (MDS); 3) the IRF-Patient Assessment Instrument (IRF-PAI); and 4) LTCH-Continuity Assessment and Record Evaluation (LTCH-CARE).

Definition of Applicable Reporting Provisions. Defines applicable PAC reporting provisions as: 1) HHA Quality Reporting Program; 2) newly required SNF Quality Reporting Program; 3) IRF Quality Reporting Program; and 4) LTCH Quality Reporting Program.

Definition of Applicable PAC Payment Systems. Defines applicable PAC payment systems as: 1) HHA Prospective Payment System (PPS); 2) SNF PPS; 3) IRF PPS; and 4) LTCH PPS.

Standardized Patient Assessment Data. Requires PAC providers to report standardized patient assessment data under the requirements of the applicable reporting provisions by October 1, 2018, for SNF, IRF and LTCH and January 1, 2019 for HHA. At a minimum, the Secretary shall require reporting at times of admission and discharge. The standardized patient assessment data shall include functional status, cognitive function, special services, medical condition, impairments, prior functioning levels, and any other categories as stated by the Secretary to be necessary and appropriate.

Alignment of Patient Assessment Data with Claims Data. The Secretary shall ensure a match between the patient assessment data submission and any claims data that is also

submitted for such patient. The Secretary shall use the matched data to assess prior and concurrent service use and for any other purposes as deemed appropriate.

Replacement of Existing Assessment Data. Requires the Secretary to revise or replace current existing patient assessment data elements that are duplicative or overlapping with the new standardized patient assessment data.

Patient Assessment Data Requirement for Inpatient Hospitals. Requires inpatient hospitals, critical access hospitals and PPS-exempt cancer hospitals to submit standardized patient assessment data by October 1, 2018. Standardized patient assessment data shall be submitted no less than one time per admission and shall include medical condition, functional status, cognitive function, living situation, access to care at home, and any other indicators necessary for assessing patient need. After two years of assessments, the Secretary shall report to Congress on the inpatient assessments and make recommendations for any changes.

Alignment with Medicare Part B Therapy Data. The Secretary shall standardize all patient assessment data with the patient assessment data collected for outpatient therapy services under Medicare Part B.

Requirement for New Quality Measures. By October 1, 2016 for SNF, IRF and LTCH and January 1, 2017 for HHA, the Secretary shall specify additional quality measures that PAC providers are required to submit under the applicable reporting provisions. The measures shall address, at a minimum, the following quality domains: 1) functional status and changes in function; 2) skin integrity and changes in skin integrity; 3) medication reconciliation; 4) incidence of major falls; and 5) patient preference regarding treatment and discharge options.

Reporting of Quality Measures. To the extent possible, the Secretary shall require reporting of such new quality measures through the PAC assessment instruments. If the Secretary is unable to modify such PAC assessment instruments prior to the new quality measure due date, the Secretary shall require an alternative data submission mechanism with respect to the new quality measure requirement.

Requirement for Resource Use Measures. By October 1, 2016, the Secretary shall specify resource use and other measures for inclusion in the applicable reporting provisions. The resource use measures shall address, at a minimum, the following resource use domains: 1) efficiency measures to include total Medicare spending per beneficiary; 2) discharge to community; and 3) risk adjusted hospitalization rates of potentially preventable admissions and readmissions.

Adjustments for the Medicare Spending per Beneficiary Resource Use Measure. The Secretary shall adjust the measure in the same manner as in the hospital value-based purchasing program and standardize the measure for geographic payment rate differences and payment differentials consistent with the hospital value-based purchasing methodology. In addition, the Secretary shall consider aligning the measure with respect

to episode length in a similar way to what is used for the Medicare spending per beneficiary measure under hospital value-based purchasing. Finally, the Secretary shall consider making adjustments based on studies required under the bill, regarding socioeconomic status and other factors, to the quality and resource use measures.

Waivers for New Quality and Resource Use Measures. The Secretary may specify the new quality and resource use measures without the use of endorsement by a consensus-based entity if endorsement is not feasible and practical. In addition, the Measure Application Partnership process, described at 1890A of the SSA, is optional for measures explicitly required by this section.

Feedback Reports to PAC Providers. By October 1, 2017, the Secretary shall provide confidential feedback reports to PAC providers on the performance of the providers with respect to all quality measures and resource use measures under the applicable reporting provisions.

Public Reporting of PAC Provider Performance. By October 1, 2018 for SNF, IRF and LTCH and January 1, 2019 for HHA, the Secretary shall create procedures for making available to the public information pertaining to individual PAC performance related to the new quality and resource use measures. The Secretary shall establish a process to allow PAC providers the opportunity to review and submit corrections to the quality and resource use data prior to public reporting of the information.

Removing and Adding Quality and Resource Use Measures. The Secretary may exclude or add a quality or resource use measure specified under an applicable reporting program, as long as it is published in the Federal Register with a justification. The Secretary is exempt from this requirement if immediate removal of a measure is necessary in order to avoid patient harm.

Studies of Alternative PAC Payment Models. Requires the Medicare Payment Advisory Commission (MedPAC), using data from the Post-Acute Payment Reform Demonstration, to submit to Congress a report that evaluates and recommends features of a PAC payment system or systems that establish payment rates according to individual characteristics instead of the setting where the patient is treated. Such report shall be due no later than June 30, 2016.

Requires both HHS and MedPAC to submit reports to Congress, including recommendations and a technical prototype, on a PAC payment system that establishes payment rates according to individual characteristics instead of the setting where the patient is treated. Such reports shall be designed to account for availability of standardized patient assessment data in subsequent years. The reports are due two years after HHS has collected two years of quality data required under this Act.

Patient Preference and Discharge Planning. Requires the Secretary to develop processes around using quality and resource use measures to assist providers, suppliers, beneficiaries and their families with discharge planning from inpatient or PAC settings.

Requires the Secretary to promulgate regulations modifying hospital and PAC conditions of participation in order to incorporate the use of measures into the discharge planning process.

Funding. The Secretary shall provide for transfer to CMS Program Management Account from the Federal Hospital Insurance Trust Fund \$200 million for implementation of this Act. Fifty percent of the amount is to be available on the date of enactment and the remaining fifty percent shall be equally proportioned for each of fiscal years 2015 through 2019.

Payment Consequences Under the Applicable Reporting Provisions. Creates payment consequences for failure to report standardized assessment data, quality, resource and other measures for PAC providers, and consequences for other providers for failure to report assessment data.

Requires HHA submission of quality and resource use measures beginning Calendar Year (CY) 2017 under the applicable reporting program. Requires HHA submission of standardized patient assessment data beginning CY 2019 under the applicable reporting program.

Requires SNF, IRF and LTCH submission of quality and resource use measures beginning Fiscal Year (FY) 2017 under the applicable reporting program. Requires SNF, IRF and LTCH submission of standardized patient assessment data beginning FY19.

Establishes a new “SNF Quality Reporting Program” at the start of fiscal year 2019. The Secretary shall reduce the annual SNF market basket update by 2 percentage points for those SNFs that fail to report quality measures or assessment data under the SNF Quality Reporting program. The application of a penalty due to failure to report quality measures is allowed to result in a market basket update less than zero. Standardized patient assessment data is required under the new SNF Quality Reporting Program.

For CAHs, a new “CAH Quality Reporting Program” is established with payments reduced by two percentage points for failure to report standardized patient assessment data, consistent with the pay-for-reporting requirements for inpatient hospitals paid under the prospective payment system and post-acute providers. For PPS-exempt cancer hospitals, the Secretary shall reduce the annual market basket update by two percentage points for failure to report standardized patient assessment data.

Additional Studies. Requires HHS to conduct studies that examine the effect of individuals' socioeconomic status, race, health literacy, limited English proficiency, and patient activation on quality and resource use. Requires the Secretary to make recommendations on how to account for such factors in the quality and resource measures required under this Act if the Secretary finds a relationship between the factors studied and quality and resource use. Provides \$16 million for these studies, distributed from the HI and SMI Trust Funds, in a proportion the Secretary deems appropriate.