American Hospital Association

Legislative Advisory

October 16, 2014

THE IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION (IMPACT) ACT OF 2014

AT A GLANCE

Background

Signed into law on Oct. 6, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 expands the reporting requirements for post-acute care (PAC) providers. Specifically, it requires long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs) and home health (HH) agencies to report standardized patient assessment data, and quality and resource use measures. The collection of this information is intended to build a common data-reporting infrastructure for PAC providers, to align quality measurement across PAC settings, and to inform future PAC payment reform efforts. **PAC providers that fail to meet the quality measure and patient assessment data reporting requirements will be subject to a 2 percentage point reduction to the payment update under their respective Medicare payment systems.** The reporting requirements will be phased in over time. Initial reporting of some quality measures will be required for fiscal year (FY) 2017 payments to LTCHs, IRFs and SNFs and for calendar year (CY) 2017 payments to HH agencies. Patient assessment data reporting will be required for FY and CY 2019 payments.

The legislation also requires the Secretary of Health and Human Services (HHS) to make changes to the Conditions of Participation pertaining to the discharge planning process for PAC providers, inpatient prospective payment system (PPS) hospitals and critical assess hospitals. In addition, the law requires HHS and the Medicare Payment Advisory Commission to make recommendations to Congress on a PAC payment system based on patient characteristics rather than treatment setting.

The IMPACT Act offsets the cost of the law ($195 million over 10 years) by aligning the annual changes to hospice payment rates and the hospice aggregate financial cap with a common inflationary index (the hospital marketbasket), in addition to other hospice changes.

Our Take

The new reporting requirements mandated by the IMPACT Act will require significant resources to implement. However, the AHA appreciates the overall intent of the legislation – to promote a consistent, data-driven approach to quality improvement and PAC payment reform. We also are pleased that this final version of the law responds to a number of the AHA's recommendations. Specifically, the IMPACT Act does not require inpatient PPS, critical access and cancer hospitals to report patient assessment data. The law also explicitly requires consideration of risk adjustment for quality measures and resource use data and removes some potentially redundant reporting requirements. The AHA expects the Centers for Medicare & Medicaid Services to begin promulgating regulations implementing the IMPACT Act's reporting requirements in 2015. In addition, the first of IMPACT's five reports related to post-acute payment reform will be issued in 2016. The AHA will closely monitor and provide input on the implementation of this multi-faceted law to ensure that both the new reporting requirements and the payment reform studies are carried out in a fair and transparent manner.

What You Can Do

- ✓ Share this advisory with your clinical leadership team, especially your chief quality and chief medical officers, to assess the impact of the IMPACT Act's requirements on your organization.

Further Questions

If you have questions, please contact AHA Member Relations at 1-800-424-4301.

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BACKGROUND

Signed into law on Oct. 6, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 expands the reporting requirements for post-acute care (PAC) providers. Specifically, it requires long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs) and home health (HH) agencies to report standardized patient assessment data and quality and resource use measures. The collection of this information is intended to build a common data-reporting infrastructure for PAC providers, to align quality measurement across post-acute care settings and to inform future PAC payment reform efforts.

The legislation also requires changes to the Conditions of Participation (CoPs) for PAC providers, inpatient prospective payment system (PPS) hospitals and critical access hospitals pertaining to their discharge planning processes. In addition, the law requires the Department of Health and Human Services (HHS) and Medicare Payment Advisory Commission (MedPAC) to make recommendations to Congress for a PAC payment system based on patient characteristics rather than treatment setting. However, the legislation does not include immediate changes to current Medicare PAC payment systems.

This advisory contains a summary of the law's provisions. The AHA expects the Centers for Medicare & Medicaid Services (CMS) to begin promulgating regulations implementing the law's requirements in 2015. We will work with the agency to ensure the IMPACT Act is fairly implemented.

KEY PROVISIONS

General Provisions

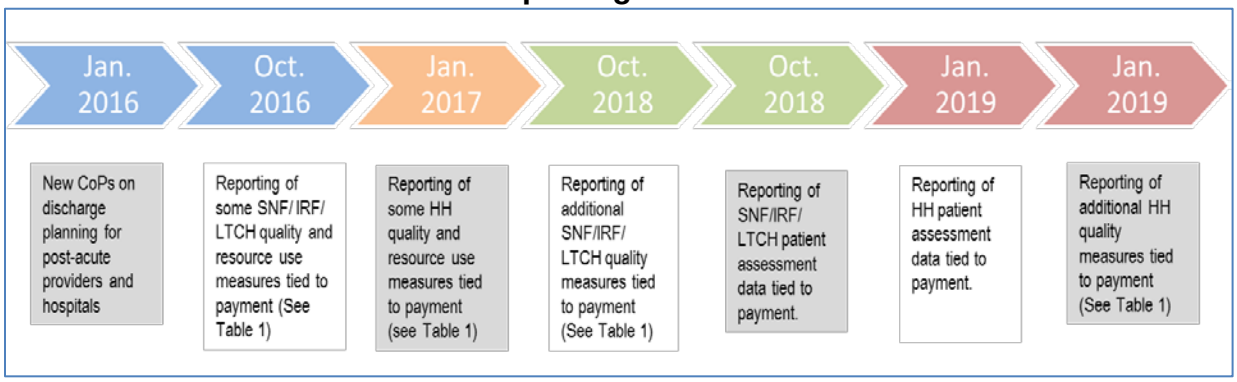
The IMPACT Act mandates the collection and reporting of specific patient assessment data and quality and resource measures by PAC providers. The new quality measures and patient assessment data must be "standardized and interoperable" across general acute-care hospitals, critical access hospitals and PAC providers. In general, this means that the measures and data should have consistent definitions across PAC

provider settings. The legislation indicates this approach will provide "longitudinal information" that "facilitate[s] coordinated care and improved [health] outcomes."

The legislation authorizes the Secretary of HHS to modify existing PAC assessment instruments to ensure that patient assessments – and any quality measures calculated from the collection of data from the assessment instruments – are standardized across PAC settings to facilitate comparisons by policy makers. The patient assessment and measure data mandated in the IMPACT Act will be used by HHS and MedPAC in the development of several reports on PAC payment reform. The legislation also requires the Secretary of HHS to promulgate changes to the discharge planning CoPs for PAC providers and hospitals that take quality measure data into account.

The reporting requirements will be phased in over time. Initial reporting of some quality measures will be required for fiscal year (FY) 2017 payment for LTCHs, IRFs and SNFs and calendar year (CY) 2017 payment for HH agencies. Patient assessment data reporting will be required for LTCHs, IRFs and SNFs for FY 2019 payment, and HH agencies for CY 2019 payment. Figure 1 below outlines the high-level timeline of these requirements.

Figure 1: IMPACT Act Quality Measure and Patient Assessment Data Reporting Timeline



Payment Consequences for Non-reporting

The legislation makes the reporting of measures and patient assessment data a requirement of the existing quality reporting programs for LTCHs, IRFs and HH agencies. Providers must report all required information in a "form and manner and at a time" established by the Secretary of HHS to avoid a 2 percentage point reduction to their annual payment updates. **As a result, LTCHs, IRFs and HH agencies that fail to report the measures or patient assessment data in accordance with requirements will be subject to a 2 percentage point payment penalty under their respective payment systems.**

SNFs do not have a "pay-for-reporting" program for quality measure or patient assessment data. As a result, the IMPACT Act includes language requiring SNFs to report measures and patient assessment data in order to avoid a 2 percentage point reduction to their payments.

Specific Patient Assessment Data-reporting Requirements

The IMPACT Act requires that the following specific patient assessment data be collected for each patient at admission and discharge:

- Functional status, such as mobility, self-care and history of falls for the period preceding the prior hospitalization, or if no antecedent hospitalization, the period preceding the post-acute admission;

- Cognitive function such as ability to express ideas and understand, and mental status such as depression and dementia;

- Special services, treatments and interventions, such as need for ventilator use, dialysis, chemotherapy, central-line placement and total parenteral nutrition;

- Medical condition and comorbidities, such as diabetes, congestive heart failure and pressure ulcers;

- Impairments, such as incontinence or an impaired ability to hear, see or swallow; and

- Other categories deemed necessary and appropriate by the Secretary.

The law allows for these data to be collected through patient assessment instruments already used by PAC providers. For example, the Secretary could use the IRF-Patient Assessment Instrument (IRF-PAI) to collect the required assessment data for IRFs. However, the Secretary has the authority to specify other standardized assessment instruments for any of the affected PAC providers.

The IMPACT Act requires that the standardized patient assessment data be aligned with Medicare claims data by Oct. 1, 2018 for SNFs, IRFs and LTCHs, and by Jan. 1, 2019 for HH agencies. This matching process is intended to be used to assess prior and concurrent service use, such as antecedent hospital or post-acute use, and may be used for other purposes. As soon as practicable, the Secretary shall revise or replace existing data requirements that duplicate or overlap with new assessment data. In addition, the law prohibits collected data from being used to require individuals to receive post-acute care or to specify a particular type of post-acute care.

Unlike for quality and resource use data, the law does not specify that the patient assessment data collected be risk adjusted or adjusted for socio-economic status. In addition, the patient assessment data will not be reported publicly.

Quality and Resource Use Measure Reporting

Quality Measures. The IMPACT Act requires PAC providers to report specific quality measures beginning with FY 2017 payment for SNFs, IRFs and LTCHs, and CY 2017 payment for HH agencies. The measure reporting requirements will be phased in over

time, as outlined in Table 1. The Secretary must include quality measures that address the following five domains:

- Functional and cognitive status;
- Skin integrity (e.g., pressure ulcers);
- Medication reconciliation;
- Incidence of major falls; and
- Communication and transfer of health information and care preferences during the following patient transitions:

    - From a general acute-care or critical access hospital to PAC, home or other applicable setting;
    - From a PAC setting to another PAC provider, general acute-care or critical access hospital, or home.

Table 1: Timeline for Payment Implications of New Quality Measure Domains*

Quality Measure Domain	IRF	LTCH	SNF	HH agencies
Functional / cognitive status	FY 2017	FY 2019	FY 2017	CY 2019
Skin integrity	FY 2017	FY 2017	FY 2017	CY 2017
Medication reconciliation	FY 2019	FY 2019	FY 2019	CY 2017
Falls	FY 2017	FY 2017	FY 2017	CY 2019
Communicating information / patient preferences	FY 2019	FY 2019	FY 2019	CY 2019

**Reflects the fiscal years and calendar years for which measure reporting will be tied to payment. FY 2017 is Oct. 1, 2016 – Sep. 30, 2017. FY 2019 is Oct. 1, 2018 – Sep. 30, 2019.*

To the extent possible, the Secretary is expected to use quality measures derived from the collection of data from PAC patient assessment instruments. However, the Secretary may make significant modifications to the PAC assessment instrument only once per year, unless she publishes a justification in the Federal Register. Additionally, the quality and resource use measures are required to be risk adjusted, taking into consideration the findings of the studies mandated by the IMPACT Act (described later in this advisory).

The Secretary is required to establish procedures to report publicly the quality measures in the above domains. Specifically, the Secretary must use the following general process:

- Within one year of measures being tied to payment, the Secretary must provide feedback reports to PAC providers. The reports must be issued quarterly if feasible, and otherwise no less than once per year. For example, the Secretary must provide a feedback report to LTCHs with data on skin integrity measure performance by FY 2018.

- Within two years of measures being tied to payment, the Secretary must report publicly the measure data. For example, the Secretary is required to report publicly the IRF functional status measures by FY 2019 since the measure is required for FY 2017. PAC providers must be provided with an opportunity to review and submit corrections to any data that are publicly reported.

Resource Use Measures. The IMPACT Act requires that the following PAC resource use data be collected from claims and patient assessment data by Oct. 1, 2016 for SNFs, IRFs and LTCHs, and by Jan. 1, 2017 for HH agencies.

- Medicare spending per beneficiary;
- Discharge to community; and
- Measures to reflect all-condition, risk-adjusted, potentially preventable hospital readmission rates.

The act specifies the following parameters for the resource use data:

- The episode length shall align with that of the inpatient PPS value-based purchasing (VBP) program. Currently, the timeframe is three days prior to and 30 days after hospital admission.

- Geographic and other adjustments to the resource use measures shall be consistent with those of the inpatient PPS VBP and spending per beneficiary measures.

- The resource use measures shall be risk adjusted. Any adjustments to the resource use measures also will be required to consider the findings of the studies mandated by the IMPACT Act, as described in a subsequent section of this advisory.

NQF Endorsement and MAP Review. In general, the quality and resource measures implemented by the Secretary of HHS must be endorsed by a "consensus-based" entity under contract with HHS. Currently, that entity is the National Quality Forum (NQF). The law also requires that measures be reviewed use the pre-rulemaking process currently operated by the Measure Applications Partnership (MAP) prior to being proposed. However, the Secretary may use non-NQF endorsed measures if none is available to meet statutory requirements. Moreover, the Secretary may waive MAP review – or use "expedited MAP review," if necessary – to meet the statutory deadlines.

CoP Changes

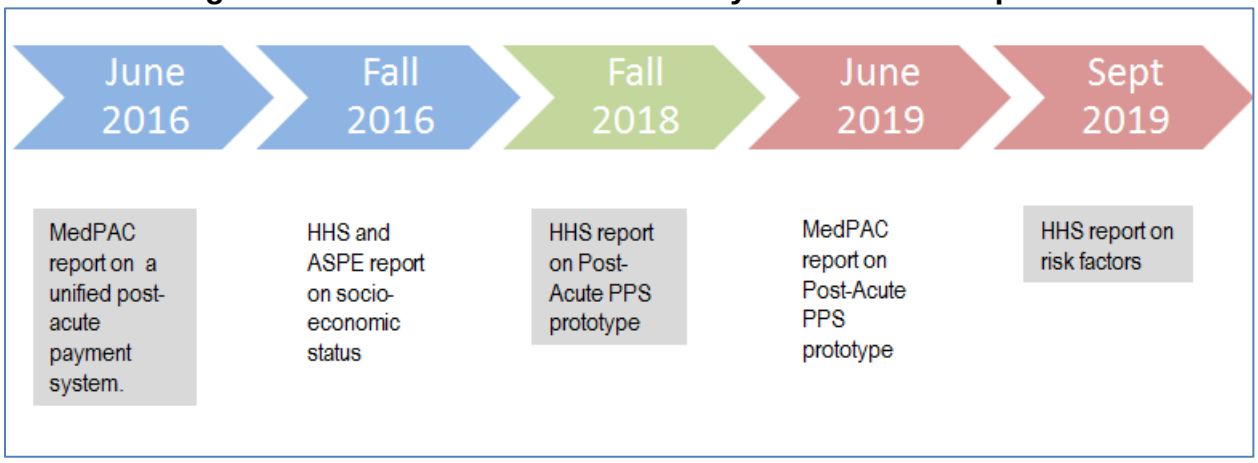
By Jan. 2016, the Secretary is required to promulgate regulations that alter the Medicare CoPs and related interpretive guidance for PAC providers and general-acute care and critical access hospitals. Specifically, the CoP changes will require the affected providers "to take into account" the quality, resource use and other measure data mandated by the IMPACT Act in their discharge planning processes. The current CoPs do not specify the data that must be taken into account during the discharge process.

The legislation specifically requires the discharge planning CoPs to be expanded to address "the setting to which a patient may be discharged," patient treatment preferences and the goals of care. The stated purpose of these requirements is to provide information that informs hospitals, PAC providers, patients and their families during transitions from a hospital or other post-acute setting. The legislation prohibits these regulations and guidance from requiring the provision of any (or a specific type of) PAC services.

Reports on Payment Reform

The IMPACT Act mandates five reports related to alternative post-acute payment models. The timing of these reports is outlined in Figure 2.

Figure 2: Timeline of IMPACT Act Payment Reform Reports



- By June 2016, MedPAC shall recommend to Congress features of a unified PAC payment system or modifications to the existing post-acute payment systems that establish payment rates based on individual patient clinical characteristics, rather than the setting. This report shall be prepared, in part, by using data from the prior PAC payment reform demonstration, which yielded the post-acute patient assessment instrument known as the "CARE Tool."

- By September 2016, the Secretary, in conjunction with the HHS Assistant Secretary for Planning and Evaluation (ASPE), shall study the effect of socio-economic status on quality of care and resource use data and make recommendations on how to account for this factor.

- Using two years of quality data collected under the IMPACT Act, the Secretary, in consultation with MedPAC, the HHS ASPE, and stakeholders, shall submit a report to Congress by fall 2018 that recommends a technical prototype of a PAC PPS. This prototype system shall be based on individual patient characteristics, incorporate patient assessment data collected under the IMPACT Act, and advance clinical integration and coordination between hospitals and PAC providers. The report also shall recommend regulations that should be altered, and assess how the new system would affect beneficiary cost-sharing, access to care and choice of setting.

An estimate of fiscal savings under the new system is to be included. In addition, the report must provide a review of the value of collecting and reporting standardized patient assessment data by hospitals.

- By June 2019, MedPAC also shall submit a report to Congress recommending a technical prototype for a new PAC PPS based on clinical characteristics (rather than the setting).

- By September 2019, the Secretary shall conduct a report on the impact of risk factors such as race, health literacy, limited English proficiency and "Medicare beneficiary activation" on quality, resource use and other data.

Hospice Offset

The IMPACT Act makes hospice-related changes that, in addition to other objectives, offset the cost of the law, $195 million over 10 years. These changes, some of which were championed by MedPAC, the HHS Office of Inspector General, and the hospice field, lower hospice payments by aligning rates and the hospice aggregate financial cap to a common inflationary index. The law also requires more frequent state surveys of hospice providers – every three years instead of every eight-plus years. And finally, the legislation authorizes medical reviews of hospice providers with a high proportion of patients treated for more than six months.

NEXT STEPS

Beginning in 2015, CMS will promulgate regulations implementing the law's requirements. The AHA recommends that you share this advisory with your clinical leadership team, especially your chief quality and chief medical officers, to assess the potential impact of the IMPACT Act's requirements on your organization.

FURTHER QUESTIONS

If you have questions, please contact AHA Member Relations at 1-800-424-4301.