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) 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 and mental status, 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. By October 1, 2018, for SNF, IRF and LTCH and January 1, 2019, for HHA, 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.

Maintaining Provider Choice. The standardized patient assessment data shall not be used to require Medicare beneficiaries to be provided post-acute care by a specific type of provider.

Requirement for New Quality Measures. The Secretary shall specify additional quality measures that PAC providers are required to submit under the applicable reporting provisions per the table below. 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.

Table 1: Timeline for New Quality Domains*				
Quality Domains	**HHAs**	**SNFs**	**IRFs**	**LTCHs**
Functional Status	1/1/2019	10/1/2016	10/1/2016	10/1/2018
Skin Integrity	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Medication Reconciliation	1/1/2017	10/1/2018	10/1/2018	10/1/2018
Major Falls	1/1/2019	10/1/2016	10/1/2016	10/1/2016
Patient Preference	1/1/2019	10/1/2018	10/1/2018	10/1/2018
*Displayed dates are deadlines for measure specification and data collection. Confidential feedback reporting and public reporting is required one and two years, respectively, after the dates displayed above,				

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) Medicare spending per beneficiary; 2) discharge to community; and 3) hospitalization rates of potentially preventable 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.

Requirements for New Quality and Resource Use Measures. The Secretary shall specify the new quality and resource use measures with the use of endorsement by a consensus-based entity. If endorsement is not feasible and practical, the Secretary is able to finalize a measure by providing a justification through notice and comment rulemaking.

In addition, the Measure Application Partnership (MAP) process, described at 1890A of the Social Security Act, shall apply. The Secretary may use expedited procedures, such as ad-hoc MAP reviews, as necessary, in the case of a quality or resource use measure under this section. However, like the endorsement process, the Secretary is able to finalize a measure without going through the MAP process only if the MAP process would preclude the Secretary from meeting a statutory deadline. The intent is for such an exception to occur infrequently.

Feedback Reports to PAC Providers. By October 1, 2017 for SNF, IRF and LTCH and January 1, 2018 for HHA, the Secretary shall provide confidential feedback reports to PAC providers on the performance of the providers with respect to all resource use measures under the applicable reporting provisions. The timeline for feedback reports on the quality measures is included in Table 1 (above).

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 resource use measures. The timeline for public reporting on the quality measures is included in Table 1 (above). 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, Suspending, and Adding Quality and Resource Use Measures. The Secretary may exclude, suspend, 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 suspension or removal of a measure is necessary in order to address patient safety concerns.

Stakeholder Input. Before the initial rulemaking process to implement this section, the Secretary shall allow for stakeholder input, such as through town halls, open door forums, and mail-box submissions.

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. In addition, MedPAC

shall report on the impact of moving from current PAC payment systems to new PAC payment systems. 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 report should also include (1) recommendations on which Medicare regulations for PAC providers should be altered (such as the SNF 3-day stay), (2) an analysis of the impact of the recommended payment system on Medicare beneficiary cost-sharing, access to care, and choice of setting, (3) a projection of any potential reduction in Medicare expenditures attributable to the application of the recommended payment system, and (4) the value of hospitals collecting and reporting standardized patient assessment data with respect to inpatient hospital services furnished to Medicare beneficiaries.

The reports shall be designed to account for availability of standardized patient assessment data in subsequent years. They 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. Such regulations and interpretive guidance shall include procedures to address patient treatment preferences and goals of care.

Payment Consequences under the Applicable Reporting Provisions. Creates payment consequences for failure to report standardized assessment data, quality, resource use 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 FY 2019.

Establishes a new "SNF Quality Reporting Program" at the start of FY 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.

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.

Funding. The Secretary shall provide for the transfer of funds to CMS Program Management Account from the Federal Hospital Insurance Trust Fund and the Supplementary Medical Insurance (SMI) Trust Fund for implementation of this Act.