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Analysis and Impact of the Improving Medicare Post-Acute Care Transformation Act of 2014

Written by Paul W. Pitts, David S. Christy and Debra A. McCurdy

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Table of Contents

Page

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Written by Paul W. Pitts, David S. Christy and Debra A. McCurdy

This week, President Obama signed into law the Improving Medicare Post-Acute Care Transformation Act of 2014 (the "IMPACT Act" or "Act").[1] The IMPACT Act's provisions will affect a broad range of post-acute care ("PAC") providers: home health agencies ("HHAs"), skilled nursing facilities ("SNFs"), inpatient rehabilitation facilities ("IRFs"), and long-term acute care hospitals ("LTCHs"). Various facets of daily operations of these PAC providers will change as a result of the Act: what information PAC providers must collect and report, the information the public will receive about PAC providers, and even the method of determining future Medicare payments to PAC providers, among others.

Policymakers have long expressed concerns with the disparate methods of paying for PAC services that may, to some degree, be substitutes for one another or complements to each other.[2] According to the preamble of the bill, the Act is intended to provide standardized assessment data for quality improvement, payment, and discharge planning purposes across the spectrum of PAC providers.

The IMPACT Act has four stages of implementation: (1) the data collection, reporting, and analysis stage; (2) the feedback report stage; (3) the public report stage; and (4) the Congressional report stage. First, the PAC providers affected by the IMPACT Act must collect and report various types of data on Medicare beneficiaries in their care using prescribed assessment instruments. The Secretary of Health and Human Services ("HHS"), and more likely her designee, the Centers for Medicare & Medicaid Services ("CMS"), then analyzes that data. Second, the Secretary provides the PAC providers with a feedback report, analyzing the PAC providers' performance on the metrics measured. Third, the Secretary releases the data on the PAC providers' performance to the public. Finally, the Secretary and the Medicare Payment Advisory Commission ("MedPAC") submit reports to Congress recommending future payment plans for PAC providers, and analyzing their effect on the metrics measured, as well as any financial effects.

The IMPACT Act could significantly increase the burden on PAC providers to maintain and report more data and clinical measures on each individual patient. At the same time, the law gives the Secretary some discretion in adding or removing factors from the collection, analysis, and reporting mandated, which presents PAC providers with the opportunity to work with CMS on the development and implementation of the new reporting systems. In the long-term, the IMPACT Act aims to provide a foundation of data upon which Congress can debate possible changes to the Medicare payment system for PAC providers.

In addition to the above-noted data collection and reporting provisions, the IMPACT Act makes several changes important to Medicare-certified hospice programs, including more frequent surveys, clarification on when medical

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[1] H.R. 4994, 113th Cong. (2nd Sess. 2014).

[2] *See e.g.* Post-Acute Care Payment Reform Demonstration Final Report (March 2012) (available here: *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Research-Reports-Items/PAC_Payment_Reform_Demo_Final.html*); see also Post-Acute Care Providers: Steps toward Broad Payment Reforms, MedPAC Report to Congress (March 2014) (available here: *http://www.medpac.gov/documents/reports/chapter-7-post-acute-care-providers-steps-toward-broad-payment-reforms-(march-2014-report).pdf?sfvrsn=2*).

reviews are performed, and a change in the annual process to calculate the payment cap that limits each hospice provider's aggregate Medicare payments per year.

Data Collection, Reporting, and Analysis

Under the IMPACT Act, PAC providers must collect and report to HHS standardized and interoperable patient assessment data, quality measures, and resource use measures. Rather than mandate a single assessment tool for all PAC providers, the Act requires the use of separate, but uniform, assessment instruments to collect and report the patient assessment data, quality measures, and resource use measures.[3] This approach is intended to facilitate the submission of standardized data, capable of comparison across all PAC providers (i.e., interoperability).

HHAs must collect and report the data and measures using the Outcome and Assessment Information Set, commonly referred to as OASIS.[4] SNFs must collect and report the data and measures using the Resident Assessment Instrument/Minimum Data Set.[5] IRFs must collect and report the data and measures using the IRF-Patient Assessment Instrument. LTCHs must collect and report data and measures using the LTCH-Continuity Assessment Record and Evaluation.

Reporting Patient Assessment Data

PAC providers must begin reporting patient assessment data in a standardized and interoperable format according to a specific schedule outlined in the Act. SNFs, IRFs, and LTCHs must begin reporting this data no later than October 1, 2018. HHAs must begin reporting this data no later than January 1, 2019.

The standardized and interoperable patient assessment data that PAC providers must report are defined as, at least: (1) functional status; (2) cognitive function and mental status; (3) special services, treatments, and interventions required; (4) medical conditions; and (5) impairments. The Secretary is granted the authority to require reporting of other categories of patient assessment data as deemed necessary and appropriate. PAC providers must report this data at admission and discharge of a patient, and more frequently if the Secretary deems appropriate.

The Secretary will match any available claims data for individual patients with their assessment data. For SNFs, IRFs, and LTCHs, the Secretary will match this data by October 1, 2018, to the extent practicable. For HHAs, the Secretary will match the data by January 1, 2019, to the extent practicable. The Secretary will use this matched data for the purpose of assessing prior service use and concurrent service use, and the Secretary may also use the data for other uses deemed appropriate. The Secretary and HHS cannot, however, use the matched claims and assessment data to require that individuals receive post-acute care from a specific type of provider to be eligible for payment.

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[3] The Secretary must modify the PAC assessment instruments as necessary to enable their use for the purposes required by the Act; however, changes may not occur more than once per calendar or fiscal year, unless the Secretary publishes a justification for the modification in the *Federal Register*.

[4] *See* 42 C.F.R. § 484.55; *see also id.* § 484.250.

[5] *See* 42 U.S.C. § 1395i-3(b)(3)(A).

Reporting Quality Measures and Resource Use Measures

In addition to the patient assessment data, PAC providers must begin reporting quality measures and resource use measures in a standardized and interoperable format.

Quality Measures Defined

The quality measures that PAC providers must report are defined as, at least:

- Functional status and cognitive function, and changes in function
- Skin integrity and changes in skin integrity
- Medication reconciliation
- Incidence of major falls
- Accurately communicating the existence of, and providing for, the transfer of an individual's health information and care preferences to the individual and others in charge of caring for, or providing services for, the individual when:
  - The individual transitions from a hospital or critical access hospital to another PAC provider or the individual's home, or
  - The individual transitions from a PAC provider to another applicable setting (including a different PAC provider, a hospital, a critical access hospital, or the home of the individual)

The Secretary may require reporting other necessary quality measures data. The Secretary also may remove, suspend, or add a quality measure or resource use measure, as long as the Secretary publishes a justification in the *Federal Register*.

The timelines for PAC providers to begin reporting on quality measures is summarized below in Table 1.

Table 1: Timeline for Reporting Quality Measures

Quality Measures	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 Health Information and Preference	1/1/2019	10/1/2018	10/1/2018	10/1/2018

Resource Use Measures Defined

The resource use measures that PAC providers must report are defined as, at least: (1) total estimated Medicare spending per beneficiary; (2) discharge to community; and (3) measures to reflect all-condition, risk-adjusted, potentially preventable hospital readmission rates. The Secretary may require reporting of other categories of resource use measures as deemed necessary.

SNFs, IRFs, and LTCHs must begin reporting resource use measures in a standardized and interoperable format no later than October 1, 2016. HHAs must begin reporting resource use measures no later than January 1, 2017, as indicated in the following table:

Table 2: Timeline for Reporting Resource Measures				
Resource Use Measures	**HHAs**	**SNFs**	**IRFs**	**LTCHs**
Resource Use Measures	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Discharge to Community	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Readmission Rates	1/1/2017	10/1/2016	10/1/2016	10/1/2016

Risk Adjustment of Measures

The Secretary will adjust the quality measures and resource use to account for clinical risk factors (e.g., age, co-morbid conditions, severity of illness), as the Secretary deems appropriate. Accounting for patients' risk factors is intended to facilitate more accurate comparison of statistics, such as the hospitalization rate of PAC patients, furthering the Act's purpose of providing standardized and interoperable PAC assessment data.

Consensus-Based Entity to Endorse Measures

Quality measures and resource use and other measures reported by PAC providers must be endorsed by a consensus-based entity with a contract under section 1890(a) of the Social Security Act (SSA), such as the National Quality Forum.[6]

PAC Providers That Fail to Report Will Be Subject to a Reduction in Market Basket Prices

Beginning with the specified dates listed in Table 1 and Table 2 above, HHAs, IRFs, LTCHs, and SNFs that fail to report quality measures and resource use and other measures will be subject to a two percentage point reduction in market basket prices in effect under the existing provisions of the SSA.[7] Similarly, beginning in 2019[8], HHAs, IRFs, and LTCHs that do not provide the required patient assessment data will be subject to the same two percentage point reduction under the SSA. Additionally, beginning with the fiscal year 2018, for SNFs that do not provide patient assessment data, the Secretary will reduce the SNF's market basket update by the same two percentage points. The reduction in percentage may result in a market basket update of less than zero. Any reduction is limited to that fiscal year, thus, reductions are not cumulative.

[6] 42 U.S.C. § 1395aaa(a). Under section 1890(a), consensus-based entities endorse measures by considering whether a measure is: "(A) evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics (i.e. health status, language capabilities, race or ethnicity, and income level); and, (B) consistent across types of health care providers, including hospitals and physicians."

[7] For HHAs, *see* 42 U.S.C. § 1395fff(b)(3)(B)(v). For IRFs, *see* 42 U.S.C. § 1395ww(j)(7). For LTCHs, *see* 42 U.S.C. § 1395ww(m)(5).

[8] For HHAs, the applicable date is the calendar year 2019. For IRFs, the applicable date is fiscal year 2019. For LTCHs, the applicable date is the rate year 2019.

Utilizing Quality Measures and Resource Use Measures in Discharge Planning

The Secretary must promulgate regulations by January 1, 2016 that will require PAC providers to take certain factors into account in the discharge planning process: (1) quality measures; (2) resource use measures; and (3) other measures under the applicable reporting provisions. Specifically, these regulations and interpretive guidance will address the settings to which a patient may be discharged in order to aid the transition for the beneficiary. The regulations and interpretive guidance will also address the treatment preferences of patients; and the goals of care of patients.

Provider Feedback Stage

Beginning one year after the dates that PAC providers must begin reporting quality measures and resource use measures, the Secretary will provide confidential feedback reports to the PAC providers on their performance regarding these measures.[9] If possible, the Secretary will provide these confidential feedback reports at least on a quarterly basis. If the PAC providers report measures on an annual basis, the Secretary may provide them confidential feedback reports annually.

Table 3: Timeline for Feedback Reports on Quality Measures

Quality Domains	HHAs	SNFs	IRFs	LTCHs
Functional Status	1/1/2020	10/1/2017	10/1/2017	10/1/2019
Skin Integrity	1/1/2018	10/1/2017	10/1/2017	10/1/2017
Medication Reconciliation	1/1/2018	10/1/2019	10/1/2019	10/1/2019
Major Falls	1/1/2020	10/1/2017	10/1/2017	10/1/2017
Patient Health Information and Preference	1/1/2020	10/1/2019	10/1/2019	10/1/2019

Table 4: Timeline for Feedback Reports on Resource Measures

Resource Use Measures	HHAs	SNFs	IRFs	LTCHs
Resource Use Measures	1/1/2018	10/1/2017	10/1/2017	10/1/2017
Discharge to Community	1/1/2018	10/1/2017	10/1/2017	10/1/2017
Readmission Rates	1/1/2018	10/1/2017	10/1/2017	10/1/2017

[9] See Table 3 for summary of feedback report deadlines for quality measures. See Table 4 for summary of feedback report deadlines for resource use measures.

Public Reporting Stage

The Secretary will then create procedures for making public the information regarding performance under the measures. Under these procedures, a PAC provider will have the opportunity to review and submit corrections to the data and information before it is made public. The information must be made public beginning no later than two years after the dates that PAC providers must begin reporting quality measures and resource use measures.[10]

Table 5: Timeline for Public Reports on Quality Measures				
Quality Measures	**HHAs**	**SNFs**	**IRFs**	**LTCHs**
Functional Status	1/1/2021	10/1/2018	10/1/2018	10/1/2020
Skin Integrity	1/1/2019	10/1/2018	10/1/2018	10/1/2018
Medication Reconciliation	1/1/2019	10/1/2020	10/1/2020	10/1/2020
Major Falls	1/1/2021	10/1/2018	10/1/2018	10/1/2018
Patient Health Information and Preference	1/1/2021	10/1/2020	10/1/2020	10/1/2020

Table 6: Timeline for Public Reports on Resource Measures				
Resource Use Measures	**HHAs**	**SNFs**	**IRFs**	**LTCHs**
Resource Use Measures	1/1/2019	10/1/2018	10/1/2018	10/1/2018
Discharge to Community	1/1/2019	10/1/2018	10/1/2018	10/1/2018
Readmission Rates	1/1/2019	10/1/2018	10/1/2018	10/1/2018

Congressional Reporting Stage

The First MedPAC Report

MedPAC must submit a report to Congress regarding alternative models for a PAC provider payment system. MedPAC is required to evaluate and recommend features of future PAC payment systems that establish, or a unified payment system that establishes, payment rates according to individuals' characteristics instead of the PAC setting in which individuals are treated. This report will be submitted no later than June 30, 2016.

[10] See Tables 5 and 6 for the respective public reporting deadlines.

Secretary's Report

In consultation with MedPAC and appropriate stakeholders, the Secretary will submit a report to Congress regarding alternative models for a PAC provider payment system. The report will include:

- Recommendations on and a technical prototype of a PAC prospective payment system that would—
  - Base payments on individual characteristics of the patient as opposed to the PAC setting
  - Account for clinical appropriateness of items and services provided and the beneficiary outcomes
  - Incorporate standardized patient assessment data received under prior sections of the IMPACT Act
  - Further clinical integration
- Recommendations on which Medicare fee-for-service regulations for PAC payment systems should be altered.
- An analysis of the impact of the recommended payment system on beneficiary cost-sharing, access to care, and choice of setting.
- A projection of any potential reduction in expenditures that may be attributable to the application of the recommended payment system.
- A review of the value of subsection (d) hospitals collecting and reporting to the Secretary standardized patient assessment data for inpatient hospital services furnished by such a hospital to Medicare beneficiaries.

This report will be submitted no later than two years after the Secretary has collected two years of data on quality measures.

The Second MedPAC Report

No later than the first June 30 following the Secretary's report, MedPAC will submit a report to Congress, including recommendations and a technical prototype for a PAC prospective payment system that would satisfy the criteria required of the prototype submitted in the Secretary's report.

HHS to Conduct Studies Concerning the Impact that Individuals' Socioeconomic Status, Race, and Other Factors Have Upon Quality and Resource Use

Not more than two years after the date of the IMPACT Act's enactment, the Secretary is required to study (and report to Congress) the effect of individuals' socioeconomic status on quality measures and resource use and other measures. Not more than five years after the date of the IMPACT Act's enactment, the Secretary will submit a report on a study to Congress regarding the impact of risk factors (such as race, health literacy, limited English proficiency, and Medicare beneficiary activity on quality measures and resource use and other measures).

Changes to Hospice Survey and Medical Review Requirements

Survey Requirement

All Medicare-certified hospice programs will be subject to more frequent surveys: no less frequently than once every 36 months, beginning in April 2015 and ending September 30, 2025. The surveys may be administered by

an appropriate state or local survey agency, or an approved accreditation agency, as determined by the Secretary.

Medical Review of Certain Hospice Care

For PAC providers certified as hospice programs, the Act changes the trigger for medical review of certain patients' care. The Affordable Care Act required medical review of hospice stays exceeding 180 days for hospices with an unusually large share of long-stay patients. Under the IMPACT Act, medical review takes place if the number of cases of patients receiving more than 180 days of care exceeds a percent of the total number of all cases of individuals cared for by the hospice at issue. This means that the trigger for such medical review of patients' hospice care will be tailored to each individual hospice program.

Hospice Payment Cap

The Act also aligns hospice reimbursement and the hospice aggregate financial cap to a common inflationary index.

Conclusion

The IMPACT Act imposes several new requirements upon PAC providers in the coming years, and may have a significant effect on the manner in which Congress addresses the question of how to modify the PAC prospective payment systems.

Through its rule-making procedures, CMS is granted significant authority to design and implement the new data collection and reporting systems, each of which has the potential to present challenges to PAC providers. Stakeholders, such as the American Hospital Association, have already questioned whether the new quality measures will be consistent with existing patient assessment measures, and whether providers will face the challenge of submitting multiple sets of distinct but similar measures. Before the initial rulemaking to implement the IMPACT Act, the Secretary must allow for stakeholder input—for example, through town halls, open door forums, and mail-box submissions. This is one way—in addition to notice-and-comment rulemaking—for PAC providers to be involved in the Act's implementation.
