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New legislation to promote standardization across PAC heralds major provider IMPACT

The IMPACT Act carries standardized quality measures and assessment criteria for postacute care providers that could set the stage for sweeping payment reform

On October 6, President Obama signed into law an historic bill intended to foster connectivity and collaboration across postacute care (PAC) settings. But although the legislation has been lauded by lawmakers, industry stakeholders, and the public, some providers are wary about the potential burden of the significant changes it bodes for the coming years.

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act ([H.R.4994](#)) is intended to standardize key data across four PAC provider types: SNFs, home health agencies, inpatient rehabilitation facilities (IRF), and long-term acute care hospitals. According to **Cynthia Morton, MPA**, executive vice president of the National Association for the Support of Long Term Care (NASL), a trade association for PAC ancillary service providers based in Washington, D.C., the primary impetus for the bill was the dearth of legislation surrounding an industry that's steadily gaining precedence as it faces

a group of older Americans who are living longer with more complex conditions and seeking PAC services like never before. Of all the Medicare beneficiaries who are discharged from the hospital, 40% transition to at least one PAC setting, and 20% of those who make the transfer are rehospitalized, Morton says.

Fittingly, legislators hope the addition of more comparable data across PAC settings will facilitate improvements to quality of care and discharge planning for this vulnerable patient population, as well as help shape future payment systems based on these criteria—an aim that's weighing heavily on many providers.

"The idea of making a more standardized patient assessment and being able to gather better data I think is appealing to most people who are working in postacute care," says **Paul Pitts, JD**, partner at Reed Smith, LLP, a global law firm headquartered in Pittsburgh, Pennsylvania, and lead author of a recent [analysis](#) of

the act. “[But] I think there’s some anxiety in terms of, how will this in the long term impact payment policy?”

In addition to the intention to usher in large-scale payment reform, the collaborative process used to create the bill—and the ease with which it was passed by a notoriously at-odds Congress—sets the IMPACT Act apart from typical legislation, according to experts.

“This was entirely different,” says Morton. “[The drafting process] truly involved stakeholders, and Congress doesn’t normally write bills like that.”

The act was drafted by a bipartisan, bicameral group of legislators based on feedback from a June 2013 survey that asked any self-identified stakeholders to peg their top areas of concern in the PAC realm. From there, the authors of the act held meetings with 45 industry groups in a two-week time frame, Morton recalls, which further influenced the direction of the bill.

Legislation rundown

According to Pitts’ analysis, the provisions of the act will be introduced in four stages:

- **Data collection, reporting, and analysis**, which will require PAC providers to implement revised assessment, quality, and resource usage measures to begin submitting “standardized and interoperable” data on their Medicare patients for review by the Secretary of Health and Human Services and CMS. SNFs will be expected to submit the assessment portion of this data—which includes information on the functional, cognitive, and mental statuses of a given patient, as well as his or her medical conditions and any special services he or she requires—no later than October 1, 2018. Reporting on quality and resource usage will begin earlier—as soon as October 1, 2016, for many of these measures.
- **Feedback reporting**, during which the Secretary will supply PAC providers with confidential feedback reports detailing their performance on studied metrics, likely on a quarterly and annual basis. The Secretary will start issuing these reports one year after the dates that PAC providers begin reporting quality and resource use measures.

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- **Public reporting**, during which the Secretary will release performance data to the public. To facilitate this process, the Secretary will develop procedures that allow PAC providers to review and submit corrections to data on their organizations before it's released to the public beginning two years after the dates that PAC providers start reporting quality and resource use measures.
- **Congressional reporting**, during which the Secretary and the Medicare Payment Advisory Commission (MedPAC) will submit recommendations to Congress about future payment plans for PAC providers, as well as analyses of the plans' prospective effect on both the studied metrics and the financial state of the industry. Specifically, MedPAC will be expected to submit two reports that weigh the validity of a PAC prospective payment system that considers criteria such as individual patient characteristics, clinical appropriateness of care delivered, and patient outcomes. The first report will also provide recommendations about which fee-for-service regulations should be altered in current payment systems. After MedPAC's initial report, the Secretary must report to Congress its recommendations for alternative payment models. Additionally, the Secretary will be expected to submit a report evaluating the effects of socioeconomic status and associated risk factors (e.g., race, health literacy, English proficiency) on quality measures and resource use within five years of the IMPACT Act's enactment.

In addition to these provisions, legislators amended the original draft of the bill with three provisions for hospice, which isn't otherwise listed among the act's targeted provider types. The most notable addition in this realm requires CMS to survey hospices for recertification at least once every three years for the next 10 years—a significant improvement over the stretches of time that can exist between these surveys today, according to industry trade groups. An August 2013 [report](#) from the Office of Inspector General found that 17% of state-surveyed hospices did not receive a survey within the preceding six years.

New assessment data

Of the four stages of the act, the first, which kindles the introduction of new measures and methods for

assessing patients, will have the most direct and immediate impact on providers, experts say.

“The big change for [SNF] providers is going to be utilizing the new assessment tools that will be incorporated into the MDS when CMS specifies them,” says **David Gifford, MD**, senior vice president of quality and regulatory affairs at the American Health Care Association in Washington, D.C.

Currently, the PAC providers affected by the IMPACT Act each use a distinct patient assessment tool (e.g., SNFs use the MDS, while IRFs use the Patient Assessment Instrument) with disparate criteria. But legislators want to standardize key assessment areas to facilitate comparison across PAC settings, a goal which could have significant implications for providers down the road, says Morton. For example, hospital discharge planners will eventually be able to use publicized performance and quality data, such as how well a PAC provider has historically treated a specific medical condition, to help a patient determine which setting is right for his or her needs. CMS also plans to use cross-setting information to gear future payment systems toward rewarding quality of care rather than quantity of services rendered, she adds.

CMS has been developing a tool to foster such standardization since the 2005 enactment of the Deficit Reduction Act triggered the agency to develop a Medicare Payment Reform Demonstration (PRD) that examined the consistency of payment incentives across the various providers that treat Medicare populations. According to the agency's website, the Continuity Assessment Record and Evaluation (**CARE**) **Item Set**, progeny of the PRD, is “designed to standardize assessment of patients' medical, functional, cognitive, and social support status across acute and post-acute settings.”

The IMPACT Act allows CMS to leverage what it learned in developing this tool in PAC settings. However, this does not mean that the standardized item set will replace the various assessment tools long used in the different PAC settings—a requirement that would place undue burden on providers, Morton says. Instead, certain items from each PAC assessment will be swapped out for questions from the CARE set for “apples-to-apples” comparisons (e.g., of how patients' capacity to eat differs and progresses from setting to setting).

“That’s where everything’s going,” Morton explains.

Although Morton says this question-level revision will be much less taxing than the introduction of an entirely new assessment used uniformly across PAC settings, she warns that providers will face a learning curve.

“It’s still going to be a change,” she says, explaining that if CMS replaces 20 questions on the MDS, providers will have to familiarize staff with the 20 new items taking their slots. “Even though [the CARE items are] replacing old [questions], they’re still new, and they still have to be wired to the RUGs because the MDS informs the RUG system ... so there is burden.”

She adds that NASL has brought concerns about this burden to Congress, and although members were receptive to the group’s questions, she says potential problem areas remain and urges providers to be attuned to future challenges the act might forecast for their practices.

Pitts echoes Morton’s advice to providers, stressing that they should raise concerns to CMS as soon as possible (e.g., through town halls, open door forums, and mailbox submissions) to increase their chances of shaping, rather than reacting to, proposed rulemaking.

Revamped quality measures

Along with new methods of reporting, the IMPACT Act heralds the introduction of new and updated quality measures during the first phase of implementation—another area that could put an additional strain on providers’ current operations. The new legislation will require PAC providers to report the following measures:

- Functional status, cognitive function, and changes in function
- Skin integrity and changes in skin integrity
- Major falls
- Medication reconciliation
- Communication and transfer of a patient’s health information and care preferences to the individual and his or her prospective caretakers when the individual transitions from (1) an acute care to a PAC setting or his or her home without further care, or (2) a PAC setting to a different PAC or acute care setting, or to his or her home without further care

SNFs will be required to begin reporting on the first three quality measures by October 1, 2016, and the final two measures by October 1, 2018.

In addition, providers must report three measures regarding patients’ resource use: total estimated Medicare spending per beneficiary, discharge to community, and potentially preventable hospital readmission rates. For SNFs, these expectations will take effect October 1, 2016.

Morton thinks the quality areas the act promotes are important to helping consumers decide which setting is best for their loved ones. Because the eventual public reporting of these measures will have significant bearing on consumers’ choice in setting, Gifford hopes CMS will risk-adjust them in a way that captures how services delivered by providers influence patients’ conditions.

“We want to make sure the measures really reflect the care that’s been provided in the SNF setting, and that it actually helps people make informed choices,” Gifford says. The act directs the Secretary to adjust quality and resource usage measures to account for clinical risk factors that may contribute to poor outcomes (e.g., age, comorbidities, severity of illness).

Although the act promises an intensified focus on quality—and new public implications forthwith—Morton clarifies that some of these measures, such as functional status and skin integrity, are nothing new for providers. Instead, the real challenge in these areas will come from trying to comply with more rigorous, uniform standards.

“Functional change, medical condition, cognitive function—a lot of facilities are already measuring [these] internally, but the big change will be that we’re going to do it according to CMS’ set quality measures ... and there’ll be growing pains with that,” she explains.

In addition, if providers fail to comply with the reporting requirements for assessment, quality, and resource use by their respective deadlines, they will experience a 2% reduction in their market basket for the fiscal year. However, although Morton says this offers further incentive for providers to ramp up their reporting processes, she hopes that SNFs’ familiarity with reporting data through the MDS will help them to avoid incurring reductions—the threat of which they should be used to by now, adds Pitts, who calls financial penalties “the way of the world ... these days.”

Start prepping

To prepare for the new expectations ahead, particularly in the quality and resource use realms, Gifford suggests evaluating the strength of current processes

and starting to bolster weak aspects as soon as possible.

“We don’t know exactly all the specifications CMS is going to provide in the future for these measures, but you know they’re going to be focusing on [these topics], so if you can get yourself looking good on those topics now, you’ll look good on whatever comes down the road,” he explains, adding that acting now is especially important because it’s hard to predict when CMS will begin incorporating content from the act into proposed rules and making changes takes time. And while Pitts thinks providers might have some leeway in fielding new expectations because planned start dates are still several years away, Morton thinks SNF providers could start seeing inklings of act provisions as early as the next proposed rule, which will come out in April 2015, because CMS has such an intensive process planned for creating and vetting new requirements, including considering input from providers and gaining the endorsement of the National Quality Forum.

Because of the potential nearness of this impact, Morton, like Gifford, recommends providers start taking stock of their internal processes surrounding MDS accuracy and adherence to quality measures. She urges providers to follow important developments surrounding the IMPACT Act—including studying the specifics of the CARE tool—to begin readying staff to adapt to the changes ahead.

“[Providers] should start [opening] their minds that we’re going to have real quality measures coming into place in the next two years,” she says. “They need to ... have their internal teams ready to accept that.”

Pitts also backs provider awareness of the IMPACT Act as it unfolds, stressing the importance of engagement as regulators begin to grapple with the difficult task of transforming the written stipulations of the act into concrete plans for achieving the legislation’s ultimate goal: payment reform.

“Postacute care providers were interested in [the act], and it was generally supported, which is why it flew through Congress ... [but] their interest might not be quite as aligned when it comes to reforming how CMS pays for services across the continuum of post-acute care,” he explains.

Indeed, Morton emphasizes that the act is not the last word on reforms in the PAC realm, but rather, an important step in an ongoing process of gathering the evidence needed to implement a payment system that promotes high-quality, patient-centered care.

“We are setting up the foundation for collecting quality measures that can ... inform pay for performance down the road,” she explains. “The law itself is a process, it’s not a result, so it’s setting the foundation for analysis that the government and MedPAC and Congress will need, and the industry too will need, to determine the next payment model.”

Pick up the progress, not the pace: Enhancing patient-centered care in SNF therapy

Therapy consultants weigh in on how to boost patient-centered care while contending with complex disciplinary demands

The modern long-term care therapy landscape is not what it used to be. As pushes for patient-centered care pervade the entire postacute sector, stakeholders increasingly advocate for greater access to and utility of home and community-based services for patients. As a result, the primary demographics of SNF residents have shifted from long-stay and permanent residents to patients who have been discharged from hospitals for

short stays in intensive rehabilitation environments. Last year, 60% of the more than 3 million Americans who were admitted to SNFs eventually returned to the community. In turn, the role of therapy in long-term care has grown and intensified—and consequently has been put under the microscope, according to some experts.

“Therapy is really being scrutinized,” says **Cindy**