Centers for Medicare & Medicaid Services

Understanding the IMPACT Act: Measure Alignment and the IMPACT Act Outcomes

Special Open Door Forum
February 2, 2016

Post-Acute Care Quality Reporting Programs (QRPs)

- Nursing Home and Home Health (HH) Compare
- Deficit Reduction Act of 2005
  - HH QRP
- Patient Protection and Affordable Care Act (2010)
  - Long-Term Care Hospital (LTCH) QRP
  - Inpatient Rehabilitation Facility (IRF) QRP
  - Hospice QRP
- Protecting Access to Medicare Act of 2014
  - Skilled Nursing Facility (SNF) VBP
- Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014
  - SNF QRP

Standardized Patient Assessment Data: Background

- MedPAC recommendations (1999, March 2014)
- 2000: Benefits Improvement & Protection Act (BIPA)
  - Report on developing standardized assessment instruments
- 2005: Deficit Reduction Act (DRA)
  - tested the concept of a common standardized assessment tool in the form of the post-acute care reform demonstration (PAC PRD). Developed the Continuity Assessment Record and Evaluation (CARE) Item Set
- 2013: PAC Reform hearing and letter to stakeholders

  "The resounding theme across the more than 70 letters received was the need for standardized post-acute assessment data across Medicare PAC provider settings."

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

- **Bipartisan bill passed on September 18, 2014 and signed into law by President Obama on October 6, 2014**

- **Requires Standardized and Interoperable Patient Assessment Data that will enable:**
  - Data Element uniformity
  - Quality care and improved outcomes
  - Comparison of quality and data across post-acute care (PAC) settings
  - Improved discharge planning
  - Exchangeability of data
  - Coordinated care

Improving Medicare Post-Acute Care Transformation Act of 2014

- Require post-acute care providers to report

  (i) standardized patient assessment data

  (ii) data on quality measures (functional status, cognitive function, and changes in function and cognitive function; skin integrity and changes in skin integrity; medication reconciliation; incidence of major falls, and; providing for the transfer of health information and care preferences)

  (iii) data on resource use and other measures (total estimated Medicare spending per beneficiary; discharge to community, and measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates)

Driving Forces of the IMPACT Act

- **Purposes Include:**
  - Improvement of Medicare beneficiary outcomes
  - Support exchange of information among PAC and other providers
  - Provider access to longitudinal information to facilitate coordinated care
  - Enable comparable data and quality across PAC settings
  - Improve hospital discharge planning
  - Research
- **Why the attention on Post-Acute Care:**
  - Escalating costs associated with PAC
  - Lack of data standards/interoperability across PAC settings
  - Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting

Post Acute Care Matters

Long-Term Care Hospital (LTCH)

Services provided: Inpatient services include rehabilitation, respiratory therapy, pain management, and head trauma treatment.

No. of Facilities: **420**

Average length of stay: **26** days

No. of Beneficiaries: **124k**

LTCH CARE – LTCH Continuity Assessment Record and Evaluation (CARE) Data Set submissions: **76K**

Medicare spending: **$5.5** billion

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/index.html

Inpatient Rehabilitation Facility (IRF)

Services provided: Intensive rehabilitation therapy including physical, occupational, and speech therapy.

No. of Facilities: **1,166**

Average length of stay: **13** days

No. of Beneficiaries: **373k**

IRF-PAI – IRF-Patient Assessment Instrument (PAI) submissions: **492k**

Medicare spending: **$6.7** billion

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html

Home Health Agency (HHA)

Services provided: Skilled nursing or therapy services provided to Medicare beneficiaries who are homebound.

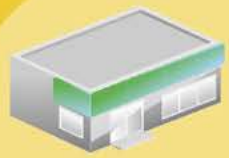
No. of Facilities: **12,311**

No. of Beneficiaries: **3.4** million

OASIS: Outcome and Assessment Information Set (OASIS) submissions: **35 million**

Medicare spending: **$18** billion

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html



Nursing Homes

Services provided: Short-term Skilled nursing and rehabilitation services to individuals whose health problems are too severe or complicated for home care or assisted living.

No. of Facilities: **15,000**

Average length of stay: **39** days

Beneficiaries: **1.7** million

MDS – Minimum Data Set submissions: **20 million**

Medicare spending: **$28.7** billion

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html

Interoperable Standardized Patient Assessment Data Supports Transformation across the Care Continuum

GG0160. Functional Mobility
(Complete during the 3-day assessment period.)

Code the patient's usual performance using the 6-point scale below.

CODING:
Safety and **Quality of Performance** - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

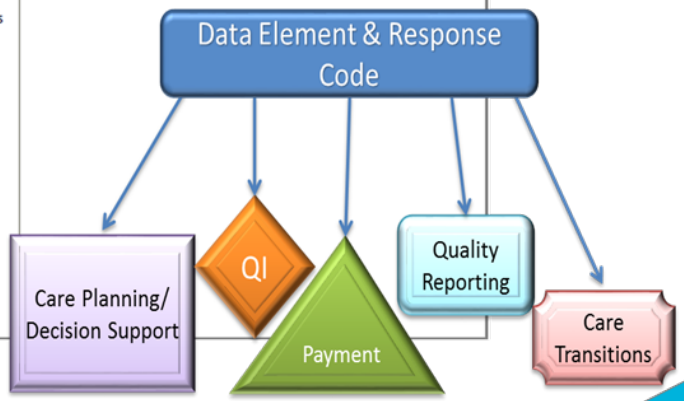
06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the task.

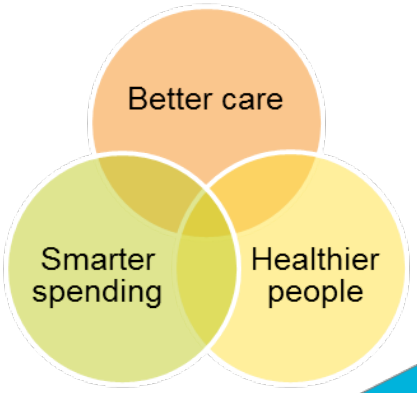
07. **Patient refused**
09. **Not applicable**

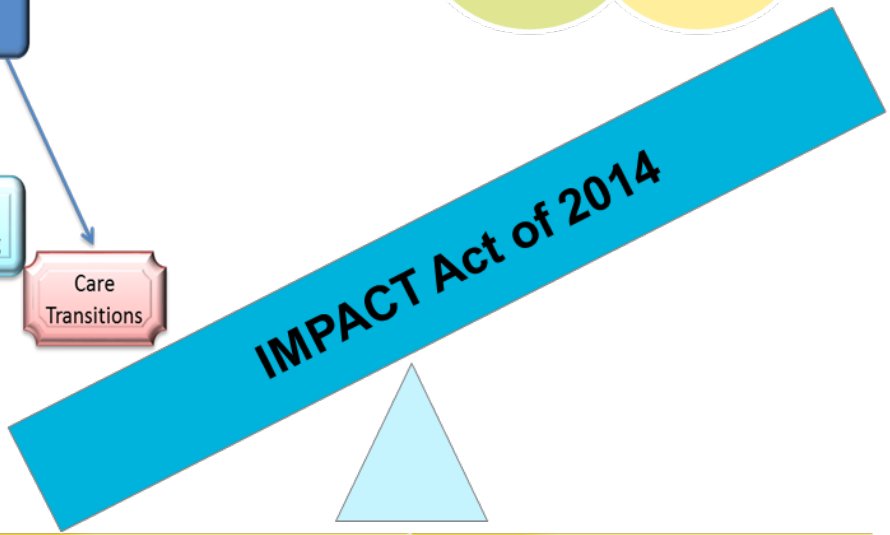
If activity was not attempted, code:
88. Not attempted due to **medical condition or safety concerns**

↓ **Enter Codes in Boxes**

☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and roll back to back.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to Sitting on Side of Bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, no back support.







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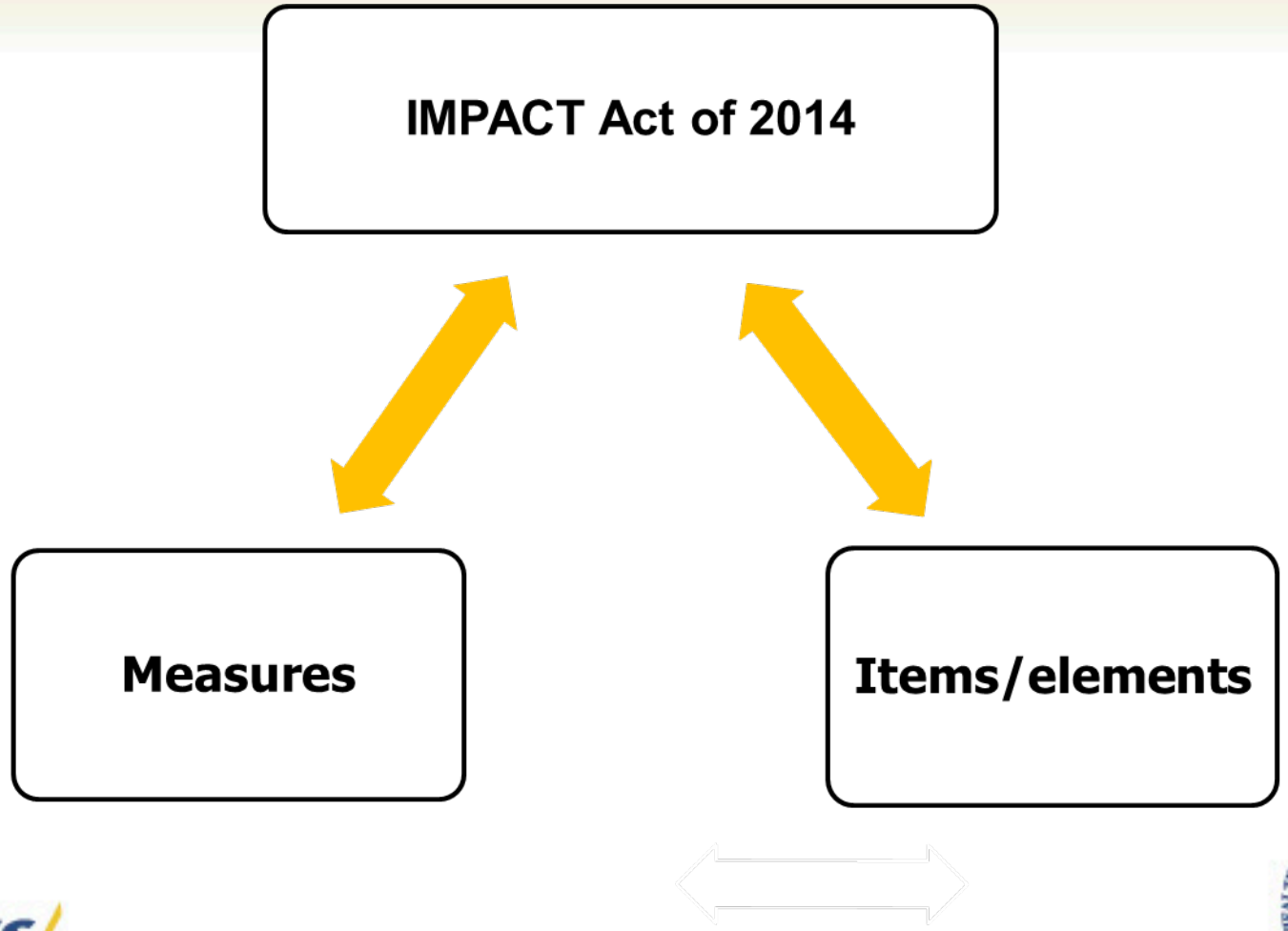
IMPACT Act: Standardizing



IMPACT Act:
Quality Measure Domains and Timelines

1	**Functional status, cognitive function, and changes in function and cognitive function**	SNF: October 1, 2016 IRF: October 1, 2016 LTCH: October 1, 2018 HHA: January 1, 2019
2	**Skin integrity and changes in skin integrity**	SNF: October 1, 2016 IRF: October 1, 2016 LTCH: October 1, 2016 HHA: January 1, 2017
3	**Medication Reconciliation**	HHA: January 1, 2017 SNF: October 1, 2018 IRF: October 1, 2018 LTCH: October 1, 2018

IMPACT Act:
Quality Measure Domains and Timelines

4 **Incidence of Major Falls**

→ SNF: October 1, 2016
IRF: October 1, 2016
LTCH: October 1, 2016
HHA: January 1, 2019

5 **Communicating the existence of and providing for the transfer of health information and care preferences**

→ SNF: October 1, 2018
IRF: October 1, 2018
LTCH: October 1, 2018
HHA: January 1, 2019

Resource use and other measures will be specified for reporting

→
- ✓ Total estimated Medicare spending per beneficiary
- ✓ Discharge to community
- ✓ Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates

→ SNF: October 1, 2016
IRF: October 1, 2016
LTCH: October 1, 2016
HH January 1, 2017

IMPACT Act: Measurement Implementation Phases

1) Measurement Implementation Phases

(A) Initial Implementation Phase –
- (i) Measure specification
- (ii) Data collection

(B) Second Implementation Phase –
Feedback reports to PAC providers

(C) Third Implementation Phase –
Public reporting of PAC providers' performance

2) Consensus-based Entity Endorsement Evaluation

3) Treatment of Application of Pre-Rulemaking Process

Measures Mapped to IMPACT Act Domains

LTCH			
Domain	**NQF ID**	**Measure Title**	**Reporting and Payment Timeline**
Skin Integrity	#0678	Percent of Residents with Pressure Ulcers That are New or Worsened (Short-Stay)	*Initial* Reporting April–December 2016 for fiscal year (FY) 2018 payment adjustment followed by CY reporting for that of subsequent FYs
Incidence of Major Falls	Application of #0674	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	
Function	Application of #2631	Percent of LTCH Patients with an Admission and Discharge Functional Assessment & a Care Plan That Addresses Function	

Measures Mapped to IMPACT Act Domains

HH			
Domain	**NQF ID**	**Measure Title**	**Reporting and Payment Timeline**
Skin Integrity	#0678	Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay)	Proposed reporting begins January 2017 for proposed calendar year (CY) 2018 payment adjustment and that of subsequent CYs

Measures Mapped to IMPACT Act Domains

SNF			
Domain	**NQF Measure ID**	**Measure Title**	**Reporting and Payment Timeline**
Skin Integrity	#0678	Percent of Residents with Pressure Ulcers That are New or Worsened (Short-Stay)	*Initial* Reporting October – December 2016 for fiscal year (FY) 2018 payment adjustment followed by CY reporting for that of subsequent FYs
Incidence of Major Falls	Application of #0674	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	
Function	Application of #2631	Percent of LTCH Patients with an Admission and Discharge Functional Assessment & a Care Plan That Addresses Function	

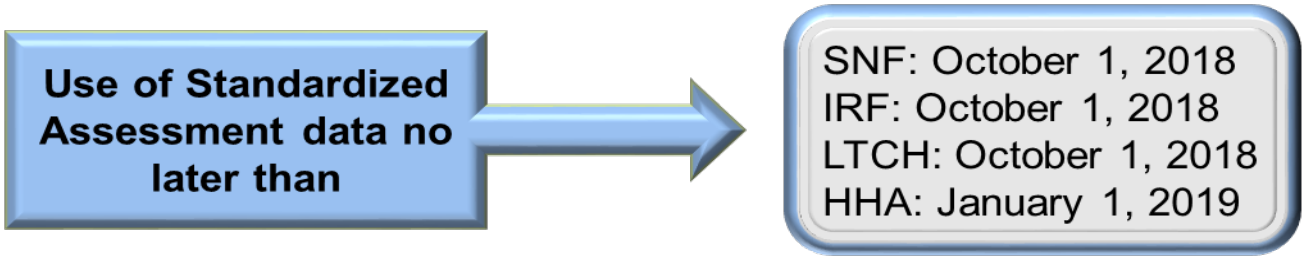
Measures Mapped to IMPACT Act Domains

IRF			
Domain	**NQF Measure ID**	**Measure Title**	**Reporting and Payment Timeline**
Skin Integrity	#0678	Percent of Residents with Pressure Ulcers That are New or Worsened (Short-Stay)	*Initial* Reporting October – December 2016 for fiscal year (FY) 2018 payment adjustment followed by CY reporting for that of subsequent FYs
Incidence of Major Falls	Application of #0674	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	
Function	Application of #2631*	Percent of LTCH Patients with an Admission and Discharge Functional Assessment & a Care Plan That Addresses Function	
Function	#2633*	Change in Self-Care Score for Medical Rehabilitation Patients	*Initial* Reporting October – December 2016 for fiscal year (FY) 2018 payment adjustment followed by CY reporting for that of subsequent FYs
Function	#2634*	Change in Mobility Score for Medical Rehabilitation Patients	
Function	#2635*	Discharge Self-Care Score for Medical Rehabilitation Patients	
Function	#2636*	Discharge Mobility Score for Medical Rehabilitation Patients	

IMPACT Act:
Standardized Patient Assessment Data

Requirements for reporting assessment data:

Providers must submit standardized assessment data through PAC assessment instruments under applicable reporting provisions



The data must be submitted with respect to admission and discharge for each patient, or more frequently as required

IMPACT Act:
Standardized Patient Assessment Data

Use of Standardized Assessment data no later than

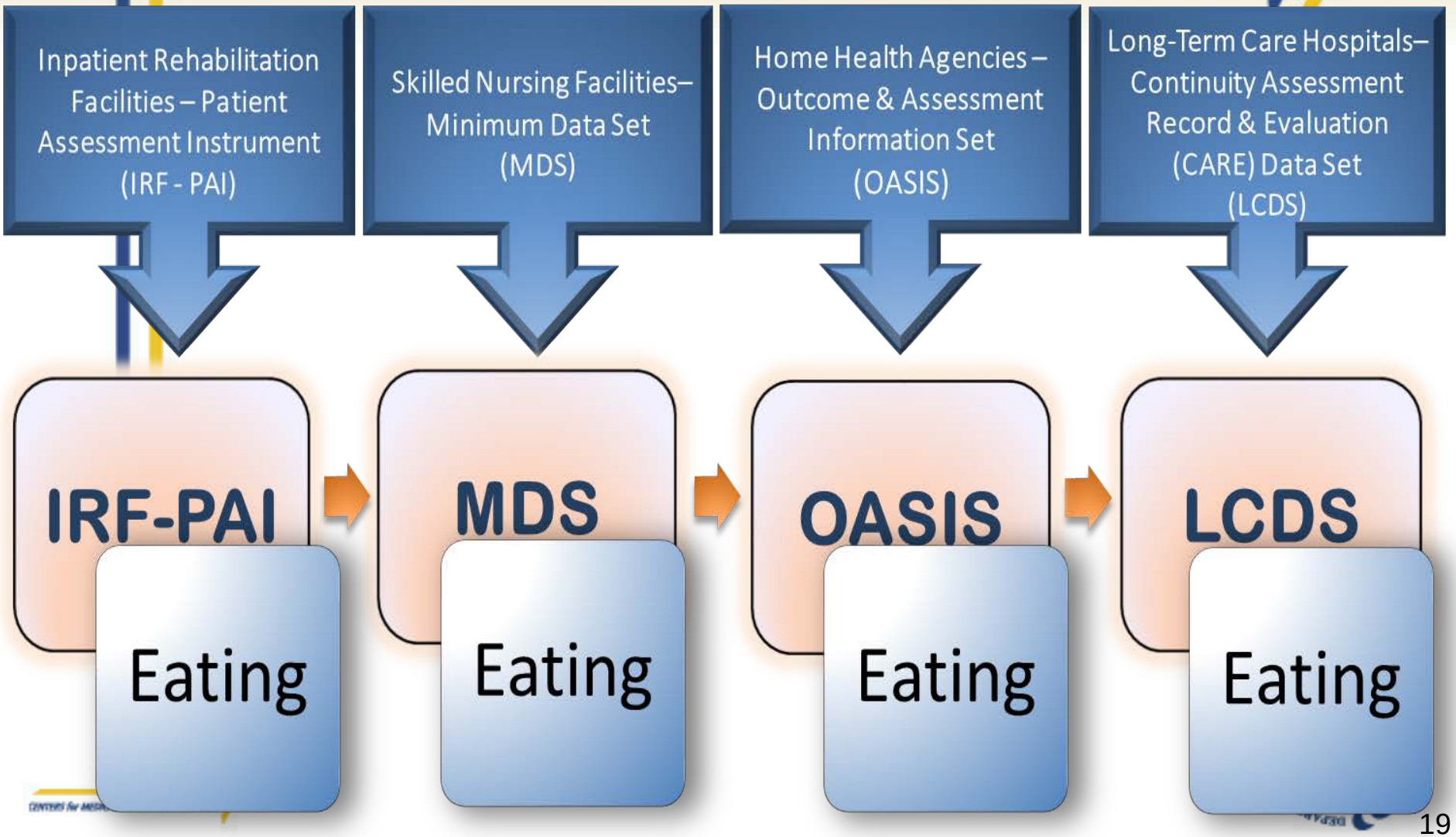
SNF: October 1, 2018
IRF: October 1, 2018
LTCH: October 1, 2018
HHA: January 1, 2019

Data categories:

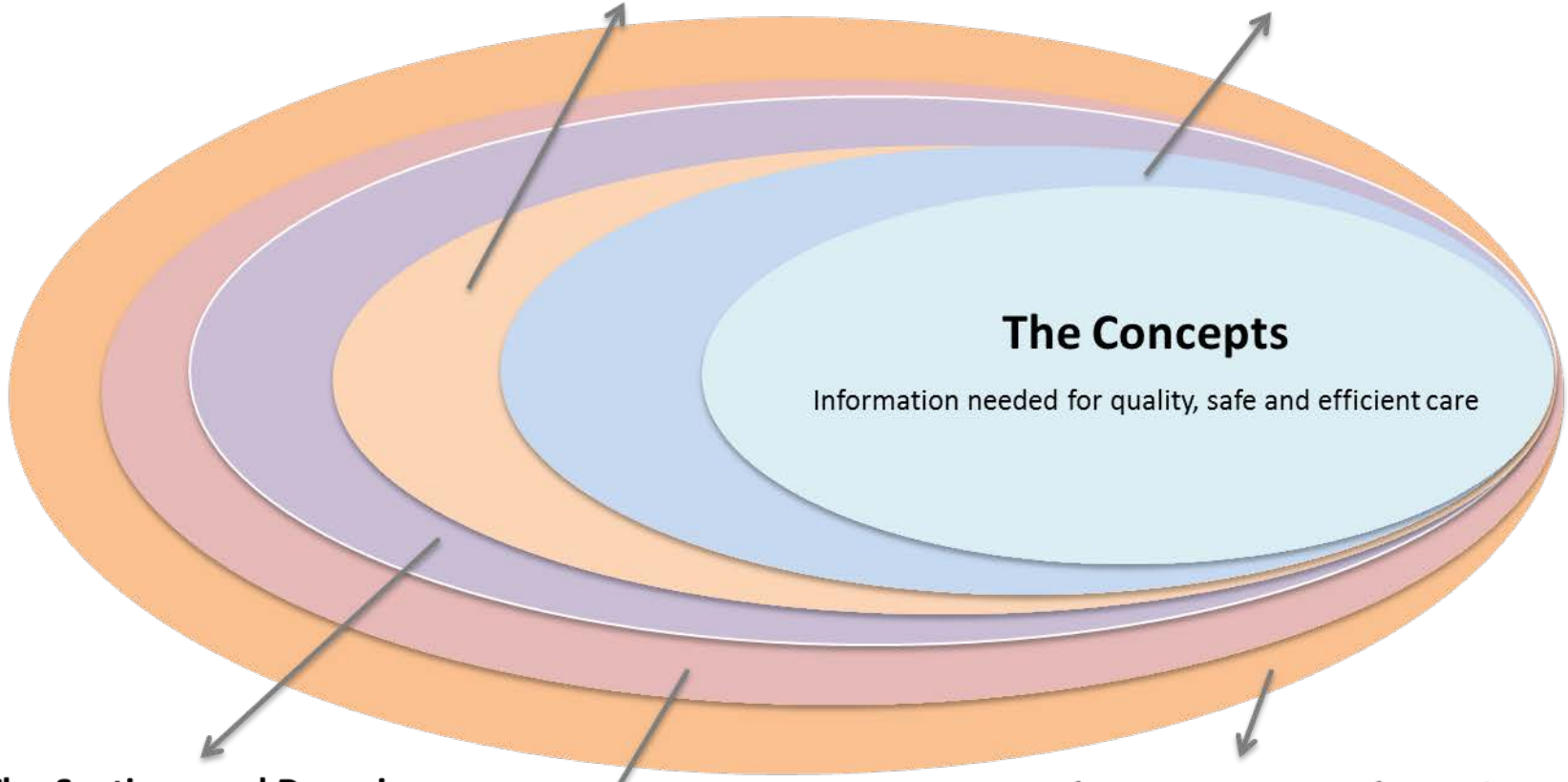
- Functional status;
- Cognitive function and mental status;
- Special services, treatments, and interventions;
- Medical conditions and co-morbidities;
- Impairments;
- Other categories required by the Secretary.

What is Standardization?

Standardizing Function at the Item Level



Assessment Instrument Components and Data Element Reuse



Percent of LTCH Patients with an Admission and Discharge Functional Assessment & Care Plan That Addresses Function

Item	Item Description	Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) v1.4	Minimum Data Set (MDS) 3.0	Long-Term Care Hospital CARE Data Set v3.00
SELF-CARE GG0130				
A	Eating	✓	✓	✓
B	Oral hygiene	✓	✓	✓
C	Toileting hygiene	✓	✓	✓
D	Wash upper body	—	—	✓
E	Shower/bathe self	✓	—	—
F	Upper body dressing	✓	—	—
G	Lower body dressing	✓	—	—
H	Putting on/taking off footwear	✓	—	—

Percent of LTCH Patients with an Admission and Discharge Functional Assessment & Care Plan That Addresses Function

Item	Item Description	Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) v1.4	Minimum Data Set (MDS) 3.0	Long-Term Care Hospital CARE Data Set v3.00
MOBILITY GG0170				
A	Roll left and right	✓	—	✓
B	Sit to lying	✓	✓	✓
C	Lying to sitting on side of bed	✓	✓	✓
D	Sit to stand	✓	✓	✓
E	Chair/bed-to-chair transfer	✓	✓	✓
F	Toilet transfer	✓	✓	✓
G	Car transfer	✓	—	—
I	Walk 10 feet	✓	—	✓
J	Walk 50 feet with two turns	✓	✓	✓
K	Walk 150 feet	✓	✓	✓
L	Walking 10 feet on uneven surface	✓	—	—
M	1 step (curb)	✓	—	—
N	4 steps	✓	—	—
O	12 steps	✓	—	—
P	Picking up object	✓	—	—
R	Wheel 50 feet with two turns	✓	✓	✓
S	Wheel 150 feet	✓	✓	✓

Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

Item	Item Description	Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)	Minimum Data Set (MDS) 3.0	Long-Term Care Hospital CARE Data Set
Number of Falls Since Admission/Entry or Reentry or Prior Assessment J1900C				
C	Major Injury	✓	✓	✓

Percent of Residents with Pressure Ulcers That are New or Worsened (Short-Stay)

Item	Outcome and Assessment Information Set (OASIS)	Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)	Minimum Data Set (MDS) 3.0	Long-Term Care Hospital CARE Data Set
Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry M0800				
M0800/M1313	✓	✓	✓	✓

QM Development and Stakeholder Engagement

IMPACT Measure Domain	Technical Expert Panels	Public Comment
Medication Reconciliation	July 2015	September 2015
Discharge to Community	August 2015	November 2015
All-Condition Risk-Adjusted Potentially Preventable Hospital Readmission Rates	August 2015	November 2015
Total Estimated Medicare Spending Per Beneficiary	October 2015	January 2016

Technical Expert Panels site:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/TechnicalExpertPanels.html

Outreach & Communications

- Special Open Door Forums (SODFs) Webinars
- eNews updates
- Listening sessions
- Medicare Learning Network (MLN) activities
- YouTube videos
- Conference outreach and speaking engagements

Ongoing Outreach & Communications

- **Listserv announcements** — 250,000 providers, 500,000+ subscribers, and Medicare Administrative Contractors (MACs)

- **Special Webpage Enhancement** — dedicated IMPACT Act web presence featuring:
  - Highlights/special announcements
  - Upcoming events, educational sessions, and stakeholder input opportunities
  - HHAs dedicated IMPACT Act section
  - IRFs dedicated IMPACT Act section
  - LTCHs dedicated IMPACT Act section
  - SNFs dedicated IMPACT Act section
  - Measure Specifications
  - Resources

IMPACT Act of 2014: Skilled Nursing Facilities

Reporting of Assessment and Quality Data

" …beginning with fiscal year 2018, in the case of a skilled nursing facility that does not submit data, as applicable,… the Secretary shall reduce such percentage for payment rates during such fiscal year by 2 percentage points."

General Resources

IMPACT Act webpage:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html

Comments can be submitted to:
PACQualityInitiative@cms.hhs.gov

Questions?