The IMPACT Act:
What does it mean for you?

Presented by
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November 4, 2014

PACCR: Who Are We?

Areas of Focus

- **Forum** for national leaders in PAC policy research, including economists, clinicians, case managers, and other experts
- **Analytic hub** for cross-fertilization of **PAC research**
- **Information Dissemination** on best practices and quality of care metrics for medical and rehabilitation populations
- **IMPACT Act** Expertise: Translating Policy to Practice
- **PAC Assessment** Training and Analysis
- **Innovation Lab** for testing delivery system refinement and providing **policy feedback**

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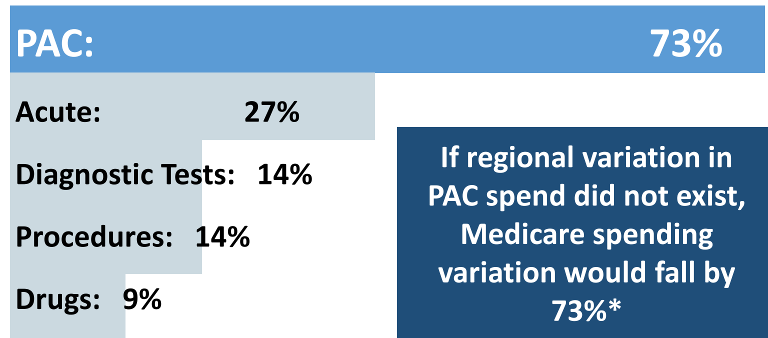
- **Carolyn Zollar**, J.D., American Medical Rehabilitation Providers Association (AMRPA)

Why PAC Reform?

- The percentage of Medicare patients utilizing PAC services following hospitalization
- The percentage of total medical spend that PAC represents
- The rate at which Medicare spending on PAC grew annually from 2001-2012



If regional variation in PAC spend did not exist, Medicare spending variation would fall by 73%*

One in five Beneficiaries are hospitalized at least once/year

- HHA: of 37.4%→ 38.2% use more
- SNF: of 41.1% → 59% use additional services
- IRF: of 10.3% → 87.7% use more
- Outpatient Therapy: of 9.1%→ 34.4% use more
- LTCH: of 2.0% → 74.9% use more

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Source: Gage et al. (2009). *Examining post-acute care relationships in an integrated hospital system*, ASPE.
*Variation in Health Care Spending, Target Decision Making, Not Geography (2013). MedPAC and IOM

Post-Acute Care Patterns of Use

High variation impacts mean episode payment and length of stay

Episode Pattern[1]	Count (5% Sample)	Percent of PAC Users (N=109,236)	Cumulative Percent	Mean Episode Payment	Mean Episode Length of Stay
AH	25,238	23.1	23.1	$ 12,696	48.9
AS	18,714	17.1	40.2	$ 17,930	44.2
ASH	8,474	7.8	48.0	$ 22,208	76.4
AO	6,533	6.0	54.0	$ 8,165	40.0
AHA	4,909	4.5	58.5	$ 25,035	57.2
AIH	3,066	2.8	61.3	$ 30,915	69.3
AHO	2,941	2.7	64.0	$ 14,250	88.0
ASAS	2,934	2.7	66.7	$ 33,346	81.7
ASA	2,092	1.9	68.6	$ 28,106	47.2
ASO	1,993	1.8	70.4	$ 18,805	87.1
AHAH	1,635	1.5	71.9	$ 26,956	171.5
AIO	1,467	1.3	73.2	$ 27,270	79.1
AI	1,382	1.3	74.5	$ 25,330	17.4

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1. A=Acute Hospital; H=HHA; I=IRF; L=LTCH; O=Outpatient Therapy; S=SNF/
Source: Gage et al. (2009). *Examining post-acute care relationships in an integrated hospital system*, ASPE

Tools Utilized Depend on Setting

- Acute Hospitals → no standard tool, varies by hospital
- Long-Term Care Hospitals → LTCH CARE
- Inpatient Rehabilitation Facilities → IRFPAI
- Skilled Nursing Facilities → MDS
- Home Health Agencies → OASIS

Comparison of Current Instruments

Similarities

- Medical complexity
- Motor Functional status
- Cognitive status
- Social support and environmental factors

Differences

- Individual items that measure each concept
- Rating scales used to measure items
- Look-back or assessment periods
- Unidimensionality of individual items

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Comparison of Tools: Functional Status

Tools	No. of Functional Items	Rating Scale Levels	Assessment Periods
IRF - PAI	18	7	Past 3 days
MDS 3.0	11	2 codes (6 &5)	Past 7 days
OASIS	8	Varies	Assessment day
CARE	**25**	**6**	**2-3 day period**

Functional Status Rating Scale

IRF-PAI/FIM® Instrument	MDS 3.0 Coding on performance & support provided	OASIS The scale varies in Meaning per item	CARE Tool
7= Complete independence	0= Independent 0= no set-up	0= independent	6= Independent with or without a device
6= Modified independence		1= (this varies with item)	
5= Supervision and Setup	1= Supervision 1= Set-up Assistance	2= (this varies with item)	5= Setup and cleanup assistance
4= Minimal Assistance	2= Limited Assistance 2= 1 person assist	3= (this varies with item)	4= Supervision or touching assistance
3= Moderate Assistance	3= Extensive Assistance 3= 2 + person assist	4= (this varies with item or is not included as a coding choice)	3= Partial/ Moderate assistance
2=Maximal Assistance	4= Total Dependence	5= (this varies with item or is not included as a coding choice)	2= Substantial
1= Total Assistance 0= Activity Did Not Occur	8= Activity NA	UK=Unknown	1= Dependent

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Deficit Reduction Act of 2005

- Mandated a PAC Payment Reform Demonstration to understand costs and outcomes across different PAC sites.
- Three components:
  1. CARE: Standardized patient assessment instrument to measure severity in hospitals, PAC settings
  2. Secure, electronic, interoperable standards-based data system for multiple providers to share essential health information/improve transitions
  3. Data collection to analyze costs and outcomes across sites (acute, SNF, HHA, IRF, LTCH)

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Continuity Assessment Record and Evaluation (CARE) Development

Based on review of existing assessment tools in Medicare program (MDS, OASIS, IRFPAI), hospital assessments + extensive input from each of the providers/research communities (hospitals, SNFs, HHAs providers/ accreditors/consumers)

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PAC Payment Reform Demonstration

Examined 3 constructs:

1. Resource Intensity
   - Routine Intensity: Nursing, case management, respiratory therapy, non-Part B services
   - Therapy Intensity: Physical therapy, occupational therapy, speech and language pathology
2. Outcomes
   - Physical Function: Self-Care
   - Physical Function: Mobility
   - Medical Status: Readmission within 30 days discharge from acute hospital
3. Discharge Destination
   - Characteristics of patients discharged to LTCH, IRF, SNF, HH as first sites of PAC under current policies

PAC PRD Report to Congress

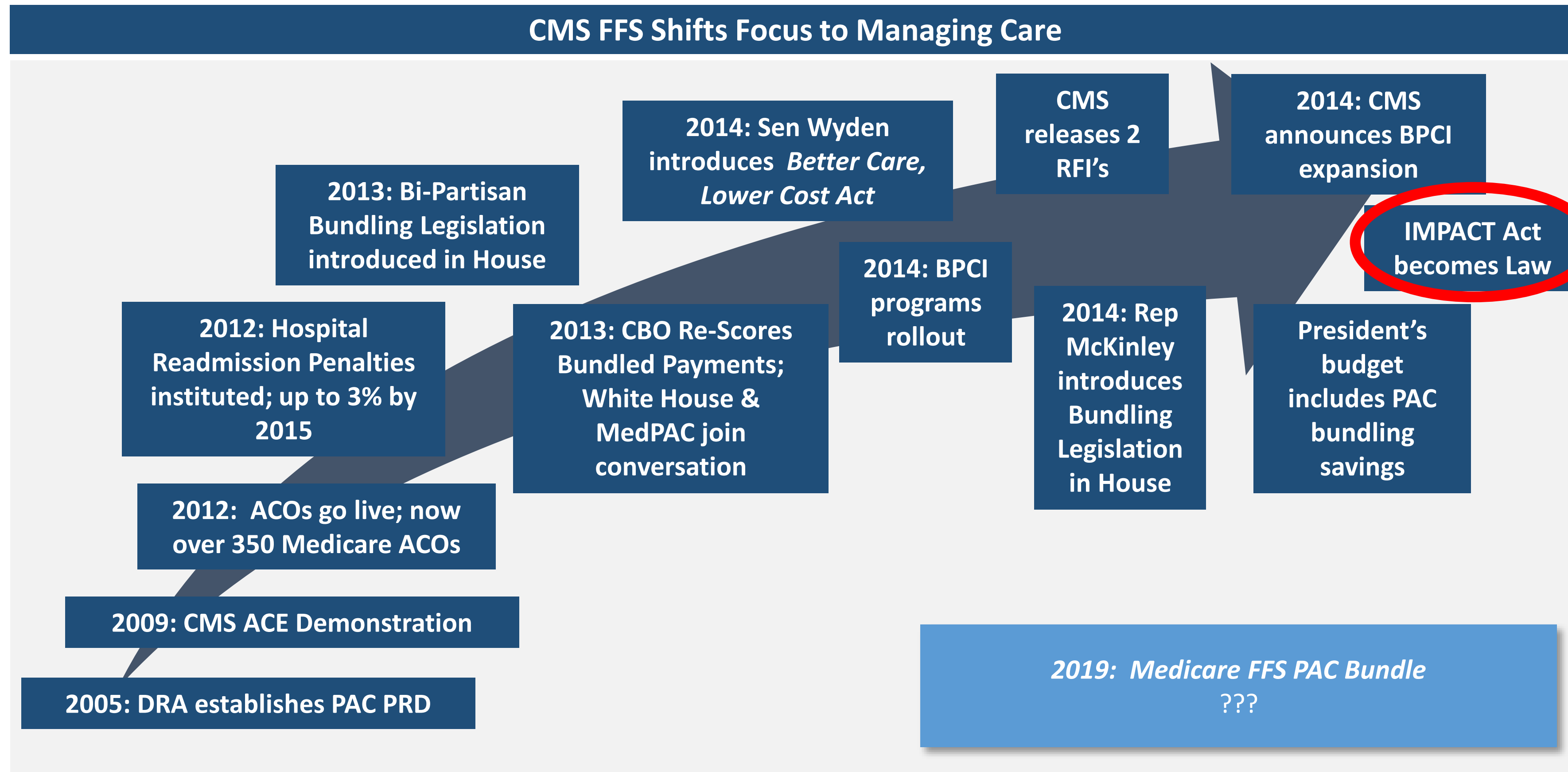
Findings:

The development of case-mix systems using uniform definitions and measures of patient acuity between different settings is possible.

- Does not require identical payment models
- Having uniform, reliable measures of patient acuity and outcomes is a positive step towards understanding differences in patient severity, needs, treatments, and outcomes in a consistent manner and helps foster better communication between providers.

Post-Acute Care Reform Momentum Building

Continued momentum and legislative initiatives to transform Medicare FFS reimbursement system, and incentivize more efficiently managed PAC



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WHY NOW?

What about the political environment combined with the payment and delivery transformation efforts underway made now the time to construct and pass legislation for Post-Acute Care?

The IMPACT Act: What does it do?

- Paves the way for "…standardizing post-acute care assessment data for quality, payment, and discharge planning, and for other purposes."
- All PAC providers including HH, SNF, IRF and LTCH's included
- Standardized collection on functional status, cognitive function, medical needs and conditions, impairments and other categories deemed necessary by Secretary
- Some data are already submitted by each PAC provider, but varies by type of provider, Act calls for replacing duplicative data collection
- Resource use data also collected to estimate per beneficiary spend
- Includes payment refinement provisions via report from MedPAC to Congress in 2016 based on PAC PRD data and report from CMS

Timeline of Activity: Home Health Agencies

January 1, 2017

- **Reporting "Quality Measures" for skin integrity**
- **Reporting "Quality Measures" for medication reconciliation**
- **Reporting "Resource Use and Other Measures"**

January 1, 2019

- **Reporting "Quality Measures" for cognitive function and functional status**
- **Reporting "Quality Measures" for occurrence of major falls**
- **Reporting "Quality Measures" for the ability of a PAC provider to relay health information, and "care preferences" of an individual**
- **Reporting "Alignment of Claims Data with Standardized Patient Assessment Data"**

Timeline of Activity: Skilled Nursing Facilities

October 1, 2016

- **Reporting "Quality Measures" for cognitive function and functional status**
- **Reporting "Quality Measures" for skin integrity**
- **Reporting "Quality Measures" for occurrence of major falls**
- **Reporting "Resource Use and Other Measures"**

October 1, 2018

- **Reporting "Quality Measures" for medication reconciliation**
- **Reporting "Quality Measures" for the ability of a PAC provider to relay health information, and "care preferences" of an individual**
- **Reporting "Alignment of Claims Data with Standardized Patient Assessment Data"**

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Timeline of Activity: Inpatient Rehabilitation Facilities

October 1, 2016

- **Reporting "Quality Measures" for cognitive function and functional status**
- **Reporting "Quality Measures" for skin integrity**
- **Reporting "Quality Measures" for occurrence of major falls**
- **Reporting "Resource Use and Other Measures"**

October 1, 2018

- **Reporting "Quality Measures" for medication reconciliation**
- **Reporting "Quality Measures" for the ability of a PAC provider to relay health information, and "care preferences" of an individual**
- **Reporting "Alignment of Claims Data with Standardized Patient Assessment Data"**

Timeline of Activity: Long-Term Care Hospitals

October 1, 2016

- Reporting "Quality Measures" for skin integrity
- Reporting "Quality Measures" for occurrence of major falls
- Reporting "Resource Use and Other Measures"

October 1, 2018

- Reporting "Quality Measures" for cognitive function and functional status
- Reporting "Quality Measures" for medication reconciliation
- Reporting "Quality Measures" for the ability of a PAC provider to relay health information, and "care preferences" of an individual
- Reporting "Alignment of Claims Data with Standardized Patient Assessment Data"

How Will This Be Implemented?

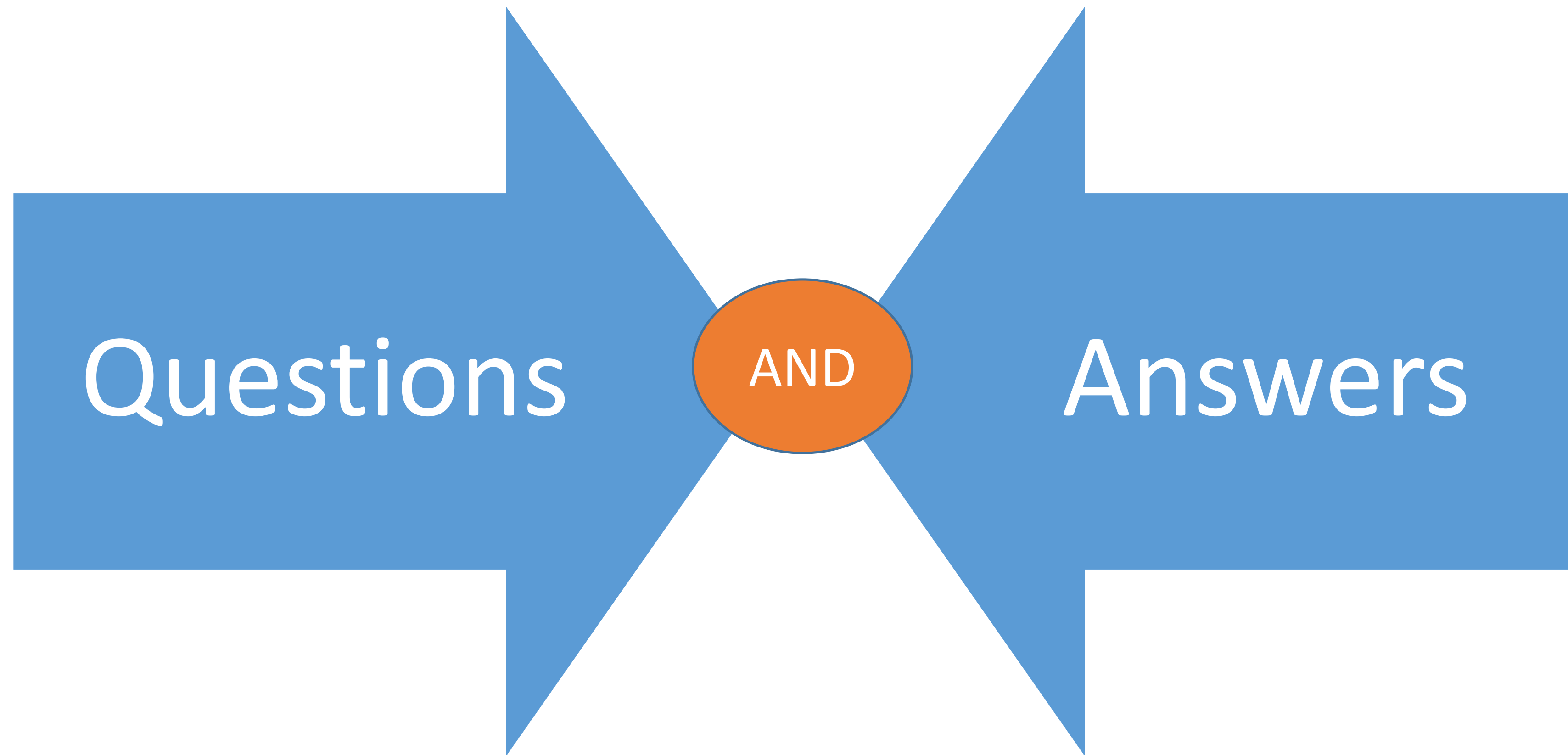
Setting-Agnostic Quality Measures

The CMS Center for Clinical Standards and Quality will develop quality metrics that can measure patient's medical, functional, and cognitive status.

Refined PAC Payment Approaches

The CMS Center for Medicare will develop standardized payment methods for:

- Chronically Critically Ill populations
- Skilled Nursing Facility populations
- Inpatient Rehabilitation Facility populations
- Home Health populations



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