Brace for IMPACT

David Brown, System Director, Rehabilitation Services, Sharp HealthCare
Pat Blaisdell, VP, Continuum of Care, California Hospital Association

August 10, 2017
Learning Objectives

- Identify the major provisions of the IMPACT Act of 2014 and current status
- Discuss operational changes and challenges for IRF providers (short-term implications).
- Identify future implications for post-acute care providers including payment reform (long-term implications).
During this presentation you will likely feel different emotions.....
HCR Changes Incentives

Current Health System

• ↑ procedures = ↑ revenue
• payment depends on site
• promotes “silos of care”
• promotes “serial” care
• limited attention to outcome
• emphasizes institutional care

Health Care Reform (HCR)

• ↑ procedures = ↑ cost
• payment depends on patient characteristics and needs rather than a specific post-acute location/site (post-acute specific).
• ↑ coordination of care
• improved care transitions
• ↑ attention to outcome
• promotion of community care and partnerships
The IMPACT Act of 2014

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BRACE FOR IMPACT

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The IMPACT Act of 2014

The Improving Medicare Post-Acute Care Transformation Act of 2014
The IMPACT Act of 2014

“Standardizing post-acute care assessment data for quality, payment and discharge planning and for other purposes.”
Per Medicare, post-acute care includes four distinct provider types:

1. Inpatient Rehabilitation Facilities (IRFs)
2. Long Term Acute Care Hospitals (LTCHs)
3. Skilled Nursing Facilities (SNFs)
4. Home Health Agencies (HHAs)
Why the IMPACT Act?
There Are a Number of Reasons

- Utilization of Post-Acute Care (PAC) Services accounts for a significant portion of Medicare-paid services and is growing rapidly.
- PAC utilization patterns and associated costs vary widely between regions across the country.
- While post-acute care provider types treat patients with similar diagnoses, each has a different and distinct payment system and patient assessment instrument.
Post-Acute Care

Utilization of PAC accounts for a significant portion of Medicare-paid services... and is growing rapidly.

- **43%** of all hospitalized Medicare patients are discharged to at least one level of post-acute care.
- **50%** of Medicare patients subsequently transfer to a 2nd or 3rd PAC venue (multi-setting usage).
- Medicare PAC spending has **doubled** since 2002, a much faster growth rate than acute care.

**Source:** MedPAC, A Data Book: Health care spending and the Medicare program, June 2016
Post Acute Care Utilization

Discharge destination for Medicare Beneficiaries

- LTCH: 1.2%
- IRF: 3.8%
- SNF: 21%
- HH: 16.8%
- Home: 55%

Source: MedPAC, A Data Book: Health care spending and the Medicare program, June 2016
Medicare Patients Highest Volume Users of PAC

Currently there are 47.6 million Medicare beneficiaries with an estimated 9,100 individuals added to the program each day. (1)

Medicare Patients’ Use of Post-Acute Services Throughout an “Episode of Care” (2)

43% of Medicare Beneficiaries are Discharged from Acute Hospitals to Post-Acute Care

Patients’ first site of discharge after acute care hospital stay

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Intensity of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-Term Acute Care Hospitals</td>
<td>Higher</td>
</tr>
<tr>
<td>Long-Term Acute Care Hospitals</td>
<td></td>
</tr>
<tr>
<td>Inpatient Rehab</td>
<td>10%</td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>41%</td>
</tr>
<tr>
<td>Outpatient Rehab</td>
<td>9%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>37%</td>
</tr>
<tr>
<td>Patients’ use of site during a 90 day episode</td>
<td>Lower</td>
</tr>
</tbody>
</table>

2% 11% 52% 21% 61%

(1) Source: U.S. Census Projections
## Readmission Rates Vary by PAC Setting

Readmission rate measures are in transition

<table>
<thead>
<tr>
<th></th>
<th>LTCH</th>
<th>IRF</th>
<th>SNF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Public Reporting</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All-cause 30 days post-d/c from PAC</td>
<td>24.6%</td>
<td>13.06%</td>
<td>21.1%</td>
</tr>
<tr>
<td><strong>Future Public Reporting</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potentially preventable, during PAC stay</td>
<td>Not available</td>
<td>2.4%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Potentially preventable, 30 days post-d/c</td>
<td>Not available</td>
<td>5.0%</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

PAC Use Varies Widely

Source: Medicare Spend Variation PBPM. NEJM – 368;16 – 18 April 2013
While post-acute care providers treat patients of similar diagnoses, each has a different payment system and assessment instrument.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Long-term Care Hospitals (LTCH-PPS)</th>
<th>Inpatient Rehabilitation Facilities (IRF-PPS)</th>
<th>Skilled Nursing Facilities (SNF-PPS)</th>
<th>Home Health Agencies (HHA-PPS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Basis</td>
<td>Per case/per hospitalization</td>
<td>Per case/per hospitalization</td>
<td>Per diem</td>
<td>Per 60-day episode of care</td>
</tr>
<tr>
<td>Case-mix adjuster</td>
<td>Diagnosis –Related Groups specific to LTCH patients (LTMS-DRG)</td>
<td>Case Mix Groups (CMG)</td>
<td>Resource Utilization Groups (RUGs)</td>
<td>Home Health Resource Groups (HHRGs)</td>
</tr>
<tr>
<td>Setting-specific Requirements</td>
<td>25% referral rule, GACH (General Acute Care Hospital) ICU stay + vent care needs. “Site-neutral” payment for certain DRGs</td>
<td>60% diagnosis rule, 3 hour therapy “rule” Rehab MD oversight and care coordination</td>
<td>Skilled need 3-day qualifying stay</td>
<td>Homebound status “Face-to-Face” certification of skilled care need.</td>
</tr>
</tbody>
</table>
Dealing with “Change”

Managing Complex Change

- Vision + Skills + Incentives + Resources + Action Plan = Change
- Vision + Skills + Incentives + Resources + Action Plan = Confusion
- Vision + Skills + Incentives + Resources + Action Plan = Anxiety
- Vision + Skills + Incentives + Resources + Action Plan = Resistance
- Vision + Skills + Incentives + Resources + Action Plan = Frustration
- Vision + Skills + Incentives + Resources + Action Plan = False Starts

IMPACT ACT - A 3 Part Series

- RTI and Abt: Standardized Quality Measurement
- RAND and Abt: Standardized Patient Assessment Data
- MedPAC and CMS: Unified PAC PPS
IMPACT ACT – 3 Part Series

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<table>
<thead>
<tr>
<th>Quality Measure Domain</th>
<th>HHA</th>
<th>SNF</th>
<th>IRF</th>
<th>LTCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional status</td>
<td>1/1/2019</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2018</td>
</tr>
<tr>
<td>Skin integrity</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>1/1/2017</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
</tr>
<tr>
<td>Incidence major falls</td>
<td>1/1/2019</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Transfer of Health Information</td>
<td>1/1/2019</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
<td>10/1/2018</td>
</tr>
<tr>
<td>Resource Use &amp; Other Measures Domain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Spending Per Beneficiary</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Discharge to Community</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
<tr>
<td>Potentially Preventable Hospital Readmissions</td>
<td>1/1/2017</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
<td>10/1/2016</td>
</tr>
</tbody>
</table>
Provisions of the IMPACT Act
New Quality Measures

Improving Medicare Post Acute Care Transformation (IMPACT) Act of 2014
Timeline for New Quality Domain Reporting

- Long Term Care Hospitals (LTCH)
  - Skin Integrity
  - Major Falls

- Home Care
  - Functional Status
  - Skin Integrity
  - Medication Reconciliation

- Skilled Nursing Facilities
  - Functional Status
  - Skin Integrity
  - Major Falls

- Inpatient Rehab Facilities
  - Functional Status
  - Skin Integrity
  - Major Falls

- Functional Status
- Patient Preference
- Medication Reconciliation

Timeline:
- 2016
- 2017
- 2018
- 2019
## Functional Status Domain Measures Across Settings

<table>
<thead>
<tr>
<th>Measure</th>
<th>Reporting Periods for FFY/CY 2018 Payment Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)</td>
<td>LTCH: January - December 2016</td>
</tr>
<tr>
<td>Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633)</td>
<td></td>
</tr>
<tr>
<td>Change in Mobility Score for Medical Rehabilitation Patients (NQF#2634)</td>
<td></td>
</tr>
<tr>
<td>Discharge Self-Care Score for Medical Rehabilitation Patients (NQF#2635)</td>
<td></td>
</tr>
<tr>
<td>Discharge Mobility Score for Medical Rehabilitation Patients (NQF#2636)</td>
<td></td>
</tr>
</tbody>
</table>

*Following the initial reporting period, all measures will be reported on a calendar year basis for the subsequent fiscal year payment adjustment.*
# Other Domains and Measures Across Settings

<table>
<thead>
<tr>
<th>Domain and Measure</th>
<th>Reporting Periods for FFY/CY 2018 Payment Determination</th>
<th>Reporting Periods for FFY 2020 Payment Determination</th>
<th>Measures not yet finalized; Statutory Deadlines for Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skin Integrity</strong>: Percent of Residents with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678)</td>
<td>LTCH: January – December 2016</td>
<td>IRF: October – December 2016</td>
<td>SNF: October – December 2016</td>
</tr>
<tr>
<td><strong>Incidence of Major Falls</strong>: Percent of Residents Experiencing one or more falls with major injury (long stay) (NQF #0674)</td>
<td>LTCH: April – December 2016</td>
<td>IRF: October – December 2016</td>
<td>SNF: October – December 2016</td>
</tr>
<tr>
<td><strong>Transfer of Health Information</strong></td>
<td>LTCH: October 1, 2018</td>
<td>IRF: October 1, 2018</td>
<td>SNF: October 1, 2018</td>
</tr>
</tbody>
</table>

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# Resource Use and Other Claims Based Measures Across Settings

<table>
<thead>
<tr>
<th>Measure</th>
<th>LTCH</th>
<th>IRF</th>
<th>SNF</th>
<th>HH</th>
</tr>
</thead>
</table>
Pending Changes to Discharge Planning Requirements

CMS has issued a *proposed* rule changing the requirements for discharge planning, as required by the IMPACT Act.

- To bring requirements into closer alignment with current practice
- Improve quality of care and outcomes
- Provide more specific requirement to improve transitions of care

Timeline for publication of the *final* rule is uncertain.
Pending Changes to Discharge Planning Requirements

Across all settings, discharge planning processes must:

• *Address the patient’s goals, needs and treatment preferences*
• Prepare patients and caregivers to participate in post-discharge care
• Requires acute hospital and PAC providers take into account quality and resource use measure to “inform” discharge planning.
CMS has established Compare websites for all PAC providers; includes QRP and claims-based measures.

CMS asks providers to encourage patients to review when choosing a provider:

- Nursing Home Compare
- IRF Compare
- LTCH Compare
- Home Health Compare
Hospitals are required to provide patient with information regarding ability to choose provider and list of eligible providers.

Hospitals may provide additional information to inform the patient’s choice – For example,

- Quality and resource use information
- Preferred provider
- Facility “report card”
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Complete
April-July 2017
Oct 2017 - May 2018

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LTCH > IRF > SNF > HHA

LTCH
April-June 2017

IRF
April-June 2018

SNF

HHA
April-June 2019
Alpha 1 Findings

- 8 Facilities in CT

- Most data element reliabilities very good and feasibility to collect good
  - *CMS only released the data elements not the protocols for when questions should be asked or other important instructions for context*

- Continued refinement needed on assessment instructions, medication reconciliation data elements and data collection protocol
  - *Data elements/questions have been eliminated and instructions revised moving to Alpha 2, but have not yet been shared*

- *Report released in May for Public Comment.*

## Proposed Standardized Patient Assessment Data Reporting

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Description</th>
<th>FY2020 IRF Quality Reporting Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Interview for Mental Status (BIMS)</td>
<td>7 questions resulting in a cognitive function score</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Confusion Assessment Method (CAM)</td>
<td>Six-question instrument screening for overall cognitive impairment</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Behavioral Signs and Symptoms</td>
<td>3 questions resulting in three scores that categorize as having or not having certain types of behavioral signs and symptoms</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Patient Health Questionnaire-2 (PHQ-2)</td>
<td>Two-item questionnaire that assesses cardinal criteria for depression</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Cancer Treatment: Chemotherapy (IV, Oral, Other)</td>
<td>Principal chemotherapy data element and three sub-elements: IV, Oral and Other</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Cancer Treatment: Radiation</td>
<td>Single Radiation data element assessing receipt of radiation therapy</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Respiratory Treatment: Oxygen Therapy (Continuous, Intermittent)</td>
<td>Principal Oxygen data element and two sub-elements: Continuous (&gt;= 14 hrs/day) or Intermittent</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Respiratory Treatment: Suctioning (Scheduled, As needed)</td>
<td>Principal Suctioning data element and two sub-elements: Scheduled (specific frequency) or As Needed (when indicated)</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>
Proposed Standardized Patient Assessment Data Reporting Cont’d

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Description</th>
<th>FY2020 IRF Quality Reporting Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Treatment: Tracheostomy Care</td>
<td>Single Tracheostomy Care data element</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)</td>
<td>Principal Non-invasive Mechanical Ventilator data element and two sub-elements: BiPAP and CPAP</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Respiratory Treatment: Invasive Mechanical Ventilator</td>
<td>Single Invasive Mechanical Ventilator data element which will be collected from the Invasive Mechanical Ventilator (Weaning) and Invasive Mechanical Ventilator (Non-Weaning) already included on LCDs</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Other Treatment: Intravenous (IV) Medications (Antibiotics, Anticoagulation, Other)</td>
<td>Principal IV Medications data element and three sub-elements: Antibiotics, Anticoagulation, and Other</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Other Treatment: Transfusions</td>
<td>Single Transfusion (introducing blood, blood products, or other fluid into the circulatory system of a person) data element</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Other Treatment: Dialysis (Hemodialysis, Peritoneal dialysis)</td>
<td>Principal Dialysis data element and two sub-elements: Hemodialysis and Peritoneal dialysis</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Other Treatment: Intravenous (IV) Access (Peripheral IV, Midline, Central line, Other)</td>
<td>Principal IV Access data element and four sub-elements: Peripheral IV, Midline, Central line, and Other</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>
## Proposed Standardized Patient Assessment Data Reporting Cont’d

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Description</th>
<th>FY 2020 IRF Quality Reporting Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutritional Approach: Parenteral/IV Feeding</td>
<td>Single Parenteral/IV Feeding (being fed intravenously using an infusion pump) data element</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Nutritional Approach: Feeding Tube</td>
<td>Single Feeding Tube data element</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Nutritional Approach: Mechanically Altered Diet</td>
<td>Single Mechanically Altered Diet (food that has been altered to make it easier for patient to chew and swallow) data element</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Nutritional Approach: Therapeutic Diet</td>
<td>Single Therapeutic Diet (meals planned to increase, decrease, or eliminate specific foods or nutrients in a diet) data element</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Hearing</td>
<td>Single Hearing data element, which assesses level of hearing impairment</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
<tr>
<td>Vision</td>
<td>Single Vision (Ability to See in Adequate Light) data element that consists of one question with five response categories</td>
<td>October 1, 2018 – December 31, 2018</td>
</tr>
</tbody>
</table>
Standardized Patient Assessment Data Process

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Sign-up deadline September 1

Complete Complete April-July 2017 Oct 2017-May 2018

CMS FY 2018 Rulemaking, April 2017, Seeking Comment from Track 1 documents

**LTCH**
April-June 2017

**IRF**
April-June 2018

**SNF**
April-June 2019

**HHA**

April-June 2019
Alpha 2 Field Test

- Field test: April – July 2017
- Three US markets:
  - Houston, Texas
  - Chicago, Illinois
  - Denver, Colorado
- 16 facilities:
  - 4 LTCH, 4 IRF, 4 SNF, and 4 HHA providers
  - 120 observational assessments
  - 120 interview admission assessments
  - 60 interview discharge assessments
Alpha 2 Data Elements

- Revised items from Alpha 1
  - Medication Reconciliation
  - Care Preferences

- New items to assess
  - Cognitive Function
  - Anxiety
  - Behavioral Signs/Symptoms

- Observation items for patients/residents who are unable to communicate to assess
  - Pain
  - Cognitive Function
  - Depressed Mood
Alpha 2 Analyses

- Feasibility of items will be evaluated based on same criteria used for alpha 1
  - Correspondence between research and facility nurse assessors
  - Time to complete
  - Qualitative feedback from assessors
- **Report of results will be generated in early fall 2017**
- CMS contractors will hold webinar for provider participants to review results and lessons learned from field test
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**LTCH > IRF > SNF > HHA**

- **LTCH**: April-June 2017
- **IRF**: April-June 2018
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**CMS FY 2018 Rulemaking, April 2017, Seeking Comment from Track 1 documents**
Beta Design – Final testing before implementation

- National sample will include:
  - 210 PAC facilities from 14 geographic/metropolitan areas
  - 28 IRFs, 28 LTCHs, 84 SNFs, and 70 HHAs
  - An average of 2 IRFs, 2 LTCHs, 6 SNFs, and 5 HHAs per PAC market
- Providers will be randomly selected to participate
- Patients/residents will be enrolled upon admission
- Design will include admission and discharge assessments
- Subset of patients/residents will be double-assessed by research and facility staff (as in Alpha test) to evaluate reliability
Beta Test Market Areas

14 geographic/metropolitan areas for Beta include:

- Boston, MA
- Harrisburg, PA
- Philadelphia, PA
- Fort Lauderdale, FL
- Durham, NC
- Chicago, IL
- Nashville, TN

- Kansas City, MO
- St. Louis, MO
- Dallas, TX
- Houston, TX
- Phoenix, AZ
- Los Angeles, CA
- San Diego, CA
Beta Recruitment Timeframe

- Mailings were sent to the broad sample in April and again in early May 2017 to invite providers to participate in Beta.
- Recruitment outreach calls from Abt Associates team members will closely follow mailings.
- Recruitment target of 210 facilities must be obtained by **September 1, 2017**.
- Field period runs from October 2017 – May 2018.
- Details regarding roles and responsibilities are included in CPAC packet:
  - This will not allow final testing to be completed prior to rulemaking.
  - Data collection by law must start October 1 2018 for most providers.
- Debrief activities will be ongoing but summarized in early Summer 2018 (only a few months before data collection to begin).
# Beta Test Assessments by PAC Type

A subset of these assessments will also be coded by a project research nurses to evaluate inter-rater reliability.

<table>
<thead>
<tr>
<th>Assessment Types</th>
<th>LTCH</th>
<th>IRF</th>
<th>SNF</th>
<th>HHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>30</td>
<td>30</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Discharge</td>
<td>21</td>
<td>28</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>Observation</td>
<td>10</td>
<td>10</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>61</strong></td>
<td><strong>68</strong></td>
<td><strong>48</strong></td>
<td><strong>46</strong></td>
</tr>
</tbody>
</table>
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Standardized Quality Measurement

RAND and Abt
Standardized Patient Assessment Data

MedPAC and CMS
Unified PAC PPS
Why Implement a Unified PAC PPS?

- Creates a uniform payment system for similar patients treated in any PAC setting
- Bases payments on patient characteristics, not where patients are treated
- Eliminates biases in the current HHA and SNF PPSs that favor treating some conditions over others

Under one proposal, reimbursement for all settings is based on patient characteristics, and distinguish between inpatient and home-based care.
Timetable for a PAC PPS Considered in the IMPACT Act of 2014

• MedPAC report June 2016
  ✓ Recommend features of a PAC PPS and estimate impacts
• Collection of uniform patient assessment information beginning October 2018 will inform subsequent reports
• Subsequent reports Due:
  ✓ Secretary’s report using 2 years’ patient assessment data (2022)
  ✓ MedPAC report on a prototype design (2023)
• Unlikely that a PAC PPS would be proposed before 2024 for implementation sometime after that
• The IMPACT Act does not require implementation of a PAC PPS

Conclusions:
• PAC “Unified Payment System” was feasible, highly desirable and could be implemented sooner than outlined in IMPACT Act.

• Include functional assessment data incorporated into the risk adjustment method when this data becomes available.

• Begin to align and consider flexibility on certain setting–specific regulatory requirements.

Design Features:
• Common unit of service and risk adjustment method

• Adjust payments for home health episodes

• Include short-stay and high-cost outlier policies

Implementation Issues

- Transition to PAC PPS
- Level of aggregate PAC payments
- The need to make periodic refinements to the PPS

• The Congress should direct the Secretary to:
  ✓ Implement a unified prospective payment system (PPS) for PAC services beginning in **2021** with a 3-year transition.
  ✓ Lower aggregate payments by **5%**, absent prior reductions to the level of payments.
  ✓ Concurrently, begin to align setting-specific regulatory requirements and
  ✓ Periodically revise and rebase payments, as needed, to keep payments aligned with the cost of care.

• Payments would decrease for rehabilitation care unrelated to the patient’s needs and increase for medically complex care.

Source: MedPAC Fact Sheet; Report to congress Medicare and the Health Care Delivery System – June 2017
www.medpac.gov
Transformation of the PAC Environment

Defined $ Amount of Reimbursement

- Capitation
- ACO
- Episodic Payment (Target Price)
- Bundling (Unified Prospective Payment)
The Need to Integrate PAC Services

- Build networks and partnerships across the post acute care continuum.
- Develop in-network and preferred provider relationships
- Collaborate with quality-based partners who can effectively control and reduce costs.
- Create clinical/care pathways
Regardless of the Payment Methodology of the Future…..

PAC Goals Need to Include:

Having hospitals manage both internal and external post-acute care provider costs and expenses.

- Managing LOS and utilization regardless of the post-acute level of care.
- Provide outstanding outcomes as Value Based Purchasing implementations will also impact all areas of post-acute care reimbursement.
- Place patients/residents in the most clinically appropriate level of post-acute care.
The IMPACT Act will require significant operational changes for all care settings in the near future. They include:

- Changing the patient assessment process in all post-acute care settings
- Increased quality reporting and data collection
- Focus on discharge planning
- Understanding the changes in payment/reimbursement and a cost management emphasis and focus
- Changes in utilization and LOS
- Development of new protocols to address new requirements
Future Focus and Priorities for PAC

The IMPACT Act underscores the important role of post acute care in health care reform.

Effective use of PAC services will:

• Support acute care LOS management
• Develop PARTNERSHIPS across the care continuum (internal and external) that will:
  ✓ Prevent unnecessary hospital readmissions
  ✓ Provide 24/7 access and availability
  ✓ Promote optimal functional outcomes
  ✓ Manage episodic care costs
  ✓ Care for high acuity and complex patients
  ✓ Emphasize strong quality ratings
HCR requires partnership across the continuum of care

Functional Recovery

Home and Community-Based Services

Post-Acute Care

Medical Recovery
With the Implementation of the IMPACT Act of 2014

• There will need to be an orchestrated, coordinated, integrated PAC team process to ensure the patient is placed in the most appropriate and proper level of care to maximize care delivery outcomes and manage costs.
## CMS Payment Framework

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<tbody>
<tr>
<td>1</td>
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<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Category</td>
<td>FFS- No link to Quality</td>
<td>FFS- Link to Quality</td>
<td>Alternative Payment Model Built Around FFS</td>
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<tr>
<td>Description of Category</td>
<td>Traditional FFS with no link to quality of efficiency</td>
<td>At least a portion of payment varies based upon quality or efficiency</td>
<td>Some payment linked to population delivery but payment still triggered by service delivery</td>
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<td>Model</td>
<td>FFS</td>
<td>• Hospital value-based purchasing</td>
<td>• ACOs</td>
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<td>• Hospital readmission reduction program</td>
<td>• Medical Homes</td>
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<td>• Hospital-acquired conditions program</td>
<td>• Bundles</td>
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<td>• Financial Alignment Demo-FFS Model</td>
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<td>Pioneer ACO (Years 3-5) Next Generation ACO</td>
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Volume to Value: Progress Toward Goals

- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)

**Historical Performance**

- 2011: ~70%
- 2014: >80%
- 2016: 85%
- 2018: 90%

**Goals**

- 2011: 0%
- 2014: 20%
- 2016: 30%
- 2018: 50%

Source: CMMI, May 2015
Questions?