The IMPACT Act amends Title XVIII of the Social Security Act to require post-acute care (PAC) providers to report and share standardized assessment data. It also requires a study of alternate payment methods for PAC providers. Identical versions of the bill were introduced to the House and Senate on June 26, 2014. The House bill was referred to the Energy and Commerce Committee and the Senate version was referred to the Finance Committee the same day. H.R. 4994 passed the House on September 16, 2014, and the Senate passed the House bill on September 18, 2014.

H.R. 4994 was introduced by Rep. Dave Camp (R-MI) garnered eight co-sponsors: Sandy Levin (D-MI), Kevin Brady (R-TX), Jim McDermott (D-WA), Earl Blementauer (D-OR), Ron Kind (D-WI), Patrick Tiberi (R-OH), Diane Black (R-TN), and Linda Sanchez (D-CA).

S. 2553 was introduced by Senator Ron Wyden (D-OR) and is cosponsored by Senator Orrin Hatch (R-UT).

District Policy Group Detailed Summary

Section I. Bill Title

The Improving Medicare Post-Acute Care Transformation Act of 2014 (known as the IMPACT Act).

Section II. Standardization of Post-Acute Care Data

Subsection (a) Requirement for Standardized Assessment Data

As soon as October 1, 2016, PAC providers must begin reporting on standardized patient assessment data, quality measures, and resource use.

Relevant Definitions

Post-Acute Care (PAC) Provider is a home health agency (HHA); a skilled nursing facility (SNF); an inpatient rehabilitation facility (IRF); or a long-term care hospital (LTCH).
**Specified Application Date** is the specific date provided for reporting requirements of particular data by particular PAC providers. (Table I outlines this information in detail.)

**Medicare Beneficiary** is an individual entitled to benefits under part A (inpatient) or, as appropriate, enrolled for benefits under part B (outpatient).

**Standardized Patient Data**
The standardized patient data required for reporting by the Act include:

- Functional status, including mobility, self-care, and/or a history of major falls.
- Cognitive function, including the ability to express ideas and understand, and an individual’s mental status.
- Special services, treatments, and interventions, including the need for ventilator, dialysis, chemotherapy, central line placement, and/or total parenteral nutrition.
- Medical conditions and comorbidities, including diabetes, congestive heart failure, and/or pressure ulcers.
- Impairments including incontinence, impaired hearing or sight, and/or the inability to swallow.
- Other categories deemed necessary and appropriate.

**Standardized Data on Quality Measures**
The standardized quality measures data required for reporting by the Act include:

- Functional status, cognitive function, and changes in function and cognitive 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 health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions:
  - From a hospital or critical access hospital (CAH) to another applicable setting, including a PAC provider or the home of the individual, or
  - From a PAC provider to another applicable setting, including a different PAC provider, a hospital, a CAH, or the home of the individual.

**Standardized Data on Resource Use and Other Measures**
The resource use and other measures required for reporting by the Act include:

- Resource use measures, including total estimated Medicare spending per beneficiary.
- Discharge to community.
Summary: The Improving Medicare Post-Acute Care Transformation Act of 2014 (The IMPACT Act) (S. 2553/H.R. 4994)

- Measures to reflect all condition risk-adjusted potentially preventable hospital readmission rates.

**Measurement Implementation**

The requirement for data reporting will be implemented in three phases.

*Phase 1*

The first phase will consist of measure specification, data collection (including requiring PAC providers to report data elements needed to calculate quality measures), and data analysis (including the use of claims data to calculate resource use and other measures).

*Phase 2*

The second phase will consist of performance feedback reports on PAC provider performance. Beginning one year after the specified application date for a particular measure, the Secretary of Health and Human Services (HHS) will provide confidential, quarterly feedback reports to PAC providers regarding their performance on quality measures and resource use. Providers will have the opportunity to respond to these reports.

*Phase 3*

The third phase will consist of public reporting on PAC provider performance. Providers will have the opportunity to review their feedback reports presented in Phase 2 and respond with corrections to the data before the information is made public. Data on quality measures and resource use will be made public no more than two years after the relevant specified application date.

**Funding**

To support these activities, the Secretary shall reallocate $130 million from the Federal Hospital Insurance Trust Fund to the Center for Medicare and Medicaid Services. Half will be available on the date of the enactment of this Act and the remainder will be evenly dispersed from fiscal year 2015 through fiscal year 2019.

**Subsection (b) Studies of Alternative PAC Payment Methods**

The Medicare Payment Advisory Commission (MedPAC) is directed to submit a report to Congress that evaluates and recommends payment rate systems that take an individual’s characteristics into account rather, than only considering the facility in which a patient is treated.

**HHS Secretary’s Recommendations for PAC Prospective Payments**

Not later than two years after HHS has collected two years of data on quality measures, the Secretary, in consultation with MedPAC and appropriate stakeholders, is required
to submit a report to Congress that includes recommendations on, and a prototype of, a PAC prospective payment system (PPS) that:

- Bases payments on patient characteristics rather than the facility in which they are treated;
- Accounts for the clinical appropriateness of items and services provided and Medicare beneficiary outcomes;
- Incorporates standardized patient assessment data; and
- Furthers clinical integration, such as by motivating greater coordination around a single condition or procedure to integrate hospital systems with PAC providers.

The report to Congress is also required to include:

- Recommendations on which Medicare fee-for-service regulations for PAC payments systems should be altered;
- An analysis of the impact of the recommended payment system on Medicare beneficiary cost-sharing, access to care, and choice of setting;
- A projection of any potential reduction in Medicare expenditures of SSA that may be attributable to the new payment system; and
- A review of the value of certain facilities.

**MedPAC Report**

No later than the first June 30th following the submission of the Secretary’s report to Congress, MedPAC is required to submit to Congress a report including recommendations and a technical prototype on a PAC PPS that satisfies the specifications in the Secretary’s report.

**Subsection (c) Payment Consequences under the Applicable Reporting Provisions**

**Table I. Specified Application Dates for Standardized Assessment Data Reporting**

<table>
<thead>
<tr>
<th>Patient Assessment Data</th>
<th>HHAs</th>
<th>SNFs</th>
<th>IRFs</th>
<th>LTCFs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional status, cognitive function, and changes in function and cognitive function</td>
<td>Jan 1, 2019</td>
<td>Oct 1, 2016</td>
<td>Oct 1, 2016</td>
<td>Oct 1, 2018</td>
</tr>
<tr>
<td>Skin integrity and changes in skin integrity</td>
<td>Jan 1, 2017</td>
<td>Oct 1, 2016</td>
<td>Oct 1, 2016</td>
<td>Oct 1, 2016</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>Jan 1, 2017</td>
<td>Oct 1, 2018</td>
<td>Oct 1, 2018</td>
<td>Oct 1, 2018</td>
</tr>
<tr>
<td>Accurately communicating</td>
<td>Jan 1, 2019</td>
<td>Oct 1, 2018</td>
<td>Oct 1, 2018</td>
<td>Oct 1, 2018</td>
</tr>
</tbody>
</table>
Summary: The Improving Medicare Post-Acute Care Transformation Act of 2014 (The IMPACT Act) (S. 2553/H.R. 4994)

|-----------------------|------------|------------|------------|------------|

Special Rule
The Secretary is directed to reduce the update of the market basket payment rates by two percent if SNFs do not report the standardized assessment data by the specified application dates for each category of data. (See above chart.)

Funding
The Nursing Home Compare Website will be funded with a one-time transfer of $11 million to the Centers for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund.

Subsection (d) Improving Payment Accuracy Under the PAC Payment Systems and Other Medicare Payment Systems

Studies Using Other Data
The Secretary is directed to conduct two studies using quality and resource use measures. The first will measure what effect, if any, socioeconomic status has on quality measures and resource use and is due to Congress three years after enactment. The second will measure what effect, if any, specified risk factors including race, health literacy, limited English proficiency, and is to be submitted to Congress five years after enactment.

CMS Activities
The Secretary is directed to carry out periodic assessments and analysis of the quality and resource use measures.

Funding
The Secretary will receive $6 million from the Hospital Trust Fund under section 1817 of the Social Security Act to carry out these studies. The Secretary will receive $10 million from the Hospital Trust Fund to carry out assessments and analysis activities.