THE REPUBLICAN STUDY COMMITTEE
Rep. Rob Woodall, Chairman
202.225.4272
rsc.woodall.house.gov

Legislative Bulletin……..……September 16, 2014

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H.R. 4994 - Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, as amended

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H.R. 4994 - Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, as amended — (Camp, R-MI)

Order of Business: H.R. 4994 is scheduled for consideration on September 16, 2014, under a suspension of the rules, which requires a two-thirds majority vote for passage.

Summary: This bill amends the Social Security Act to provide for standardized post-acute care assessment data for quality, payment, and discharge planning.

Requirement for Standardized Post-Acute Care Assessment Data:

- Requires post-acute care (PAC) providers (a home health agency, skilled nursing facility, inpatient rehab facility, or a long-term care hospital) to report standardized patient assessment data, data on quality measures, and data on resource use. This data is to be standardized and interoperable to allow for the exchange of data among providers.

Standardized Patient Assessment Data

- PAC providers will be required to submit to the Secretary of Health and Human Services the standardized patient assessment data with respect to admission and discharge of an individual. Data that is submitted must include quality measures such as: functional status, cognitive function and mental status, special services, medical condition, impairments, prior functioning levels, and any other categories as stated by the Secretary to be necessary and appropriate.
- The Secretary will then match claims data with assessment data for the purpose of assessing prior service use and concurrent service use.
- Standardized patient assessment data submitted will not be used to require individuals to be provided post-acute care by specific types of PAC providers in order for the care to be eligible for payment.

Quality Measures

- The Secretary will specify quality measures on which PAC providers are required to submit standardized patient assessment data. The measures will address, at minimum,

the following: 1) functional status and changes in function; 2) skin integrity and changes in skin integrity; 3) medication reconciliation; 4) incidence of major falls; and 5) patient preference regarding treatment and discharge options.
- This reporting will be done through a PAC assessment instrument

Resource Use
- The Secretary shall specify resource use and other measures for inclusion in the applicable reporting provisions. The resource use measures shall address, at a minimum, the following: Medicare spending per beneficiary, discharge to community, and hospitalization rates of potentially preventable readmissions.

Implementation
- The implementation will take part in three phases:
    1. Measure specification, inform the public, data collection, data analysis;
    2. Provision of feedback reports to all PAC providers, and;
    3. Public reporting of PAC providers' performance on the required measures.

Feedback Reports to PAC Providers
- The Secretary will provide confidential feedback reports to PAC providers on their performance with respect to the required measures. These reports will be provided on no less than a quarterly basis.
- The Secretary will also provide for public reporting of PAC provider performance on quality measures and resource use. The PAC provider will be given the opportunity to review and submit correction to the data prior to the data being made public.

Use of Data to Inform Discharge Planning
- The Secretary will promulgate regulations to require PAC providers to take into account quality, resource use, and other measures under the applicable reporting provisions in the discharge planning process, and more specifically, the setting to which a patient may be discharged.
- The guidance will include procedures which address the treatment preferences of patients, and the goals of care of the patients.
- For the purposes of carrying out this section, the Secretary will provide for the transfer to the CMS Program Management Account, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, $130,000,000.
    - 50 percent will be available on the date of enactment, and 50 percent will remain equally proportioned for each fiscal year 2015 though 2019.

Studies of Alternative PAC Payment Models
- The Medicare Payment Advisory Commission (MedPAC) will submit to Congress a report that evaluates and recommends features of PAC payment systems that establish payment rates according to characteristics of individuals (such as cognitive ability, functional status, and impairments) instead of according to the post-acute care setting where the Medicare beneficiary involved is treated.

- The Secretary, in consultation with MedPAC, will submit a report to Congress which makes recommendations and a technical prototype on a post-acute care prospective payment system.

Payment Consequences under the Applicable Reporting Provisions

- Includes a new subsection in the Social Security Act which requires submission of quality data and other necessary by a home health agency to the Secretary January 1, 2019. If this data is not submitted, a home health agency could be reimbursed 2 percent less under the home health market basket percentage.
- By October 1, 2016, inpatient rehabilitation facilities will need to submit additional quality measures established in this bill, in addition to the quality measures required under current law.
- For fiscal year 2018, in the case that a skilled nursing facility does not submit data, as applicable, the Secretary will reduce the percentage for payment rates by 2 percentage points.

Improving Payment Accuracy

- The Secretary will conduct a study that examines the effect of an individual's socioeconomic status, the impact of race, health literacy, limited English proficiency, and Medicare beneficiary activation on quality measurers and resource in the Medicare program.

Hospice Care

- Subjects certified hospice entities to a standard survey by the appropriate state or local agency or an approved accreditation agency no less than once every 36 months.
- Recalculates the hospice cap index using a slower growth rate.

Medicare Improvement Fund

- Amends the Medicare Improvement Fund by making available $200,000,000 to be used during and after fiscal year 2020.

Additional Background: In 2013, the Chairmen and Ranking Members of the House Ways and Means Committee and the Senate Finance Committee invited the post-acute care community to provide recommendations and ideas on how to reform the system to strengthen post-acute care. The committees received responses from more than 70 stakeholders detailing their need for standardized post-acute assessment data across Medicare PAC provider settings.

The need to standardize assessment data has been recommended by MedPAC on several occasions. MedPAC writes, "Currently, three of the four settings (HHAs, IRFs, and SNFs) are required by CMS to use different assessment instruments. While CMS successfully tested a common assessment tool across PAC settings and in acute hospitals at discharge, CMS has not established a time line to require PAC settings to gather consistent patient assessment information. To help prevent undue delays in the collection of comparable data, the Commission recommends that the Congress direct the Secretary to implement common patient assessment items for use in the four PAC settings…"

Committee Action: This bill was introduced by Representative Camp on June 26, 2014, and referred to the Committee on Ways and Means, and the Committee on Energy and Commerce where it awaits further action.

Administration Position: No Statement of Administration Policy is available at this time.

Cost to Taxpayers: According to CBO, this legislation would increase direct spending by appropriating $222 million over the 2015-2024 period for activities related to survey and certification requirements for hospices and for the development and use of standardized assessment and quality data for post-acute services furnished to Medicare beneficiaries. The legislation would authorize the Secretary of Health and Human Services to spend $200 million in 2020 or subsequent years to increase payment rates for services furnished in the fee-for-service sector.

The legislation also would reduce direct spending by reducing Medicare's payment rates for services furnished by skilled nursing facilities that do not report assessment and quality data and by reducing the caps on payments for beneficiaries receiving hospice services.

In total, CBO estimates between the years 2014-2024, there would be a net increase in the deficit of $1 million.

Does the Bill Contain Any New State-Government, Local-Government, or Private-Sector Mandates?: This bill will require PAC providers to submit additional information and quality measures to the Secretary.

Does the Bill Contain Any Federal Encroachment into State or Local Authority in Potential Violation of the 10th Amendment?: No.

Does the Bill Delegate Any Legislative Authority to the Executive Branch?: No.

Constitutional Authority: According to the sponsor, "Congress has the power to enact this legislation pursuant to the following: Article 1, section 8." Read the statement here.

RSC Staff Contact: Rebekah Armstrong, Rebekah.Armstrong@mail.house.gov, 202-226-0678

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