



# The IMPACT Act of 2014 and Updates to Skilled Nursing Facility Quality Reporting Program Requirements



**Finalized Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs) for FY 2016, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and Staffing**

Data Collection, Published 08/04/2015:  
<https://www.federalregister.gov/articles/2015/08/04/2015-18950/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities>

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**Date:** June 21, 2016



# **Data Element Uniformity, Assessment Domain Standardization, and the IMPACT Act of 2014**

The Division of Chronic & Post Acute Care  
The Centers for Medicare & Medicaid Services

**Sharon Lash**



# 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 patient assessment data across post-acute care (PAC) that will enable:
  - Quality care and improved outcomes
  - Data element uniformity
  - Comparison of quality and data across PAC settings
  - Improved, person-centered, goals-driven discharge planning
  - Exchangeability of data
  - Coordinated care



# Driving Forces of the IMPACT Act

- **Purposes include:**
  - Improvement of Medicare beneficiary outcomes
  - Provider access to longitudinal information to facilitate coordinated care
  - Enable comparable data and quality across PAC settings
  - Improve hospital discharge planning
  - Research to enable payment models based on patient characteristics
- **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

## LTCH, IRF, HH, Nursing Homes



### 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

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

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

Medicare spending: **\$5.5 billion**



### 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

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

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

Medicare spending: **\$6.7 billion**



### 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

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

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

Medicare spending: **\$18 billion**



### 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

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

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

Medicare spending: **\$28.7 billion**





# Legislative Background on Data Standardization

- **Benefits Improvement & Protection Act (BIPA) of 2000**
  - Required the Secretary to report to Congress on standardized assessment items across PAC settings
- **Deficit Reduction Act (DRA) of 2005**
  - Required the standardization of assessment items used at discharge from an acute care setting and at admission to a PAC setting
  - Established the Post-Acute Care Payment Reform Demonstration (PAC-PRD) to harmonize payments for similar settings in PAC settings
  - Resulted in the Continuity Assessment Record and Evaluation (CARE) tool, a component to test the reliability of the standardized items when used in each Medicare setting



# Legislative Background on Data Standardization (continued)

- **PAC Reform Demonstration requirement of 2006**
  - Data to meet federal Health Information Technology (HIT) interoperability standards



# Standardized Data

## Goals and Guiding Principles

### Goals

- ✓ Fosters seamless care transitions
- ✓ Data & Information that can follow the patient
- ✓ Evaluation of longitudinal outcomes for patients that traverse settings
- ✓ Assessment of quality across settings
- ✓ Improved outcomes, and efficiency
- ✓ Reduction in provider burden

### Data Uniformity

- ✓ Reusable
- ✓ Informative
- ✓ Increases Reliability/validity
- ✓ Facilitates patient care coordination

### Guiding Principles

### Interoperability

- ✓ Data that can communicate in the same language across settings
- ✓ Data that can be transferable forward and backward to facilitate care coordination
- ✓ Follows the individual



# NQS Promotes Better Health, Better Healthcare, and Lower Costs Through:

- Make care safer by reducing harm caused in the delivery of care
- Ensure that each person and family are engaged as partners in their care
- Promote effective communication and coordination of care
- Promote effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- Work with communities to promote wide use of best practices to enable healthy living
- Make quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models

## *Report to Congress*

National Strategy for Quality  
Improvement in Health Care

March 2011



# The Six Priorities Have Become the Goals for the CMS Quality Strategy

**Making Care Safer**

**Strengthen person &  
family engagement**

**Promote effective  
communication &  
coordination of care**

**Promote effective  
prevention & treatment**

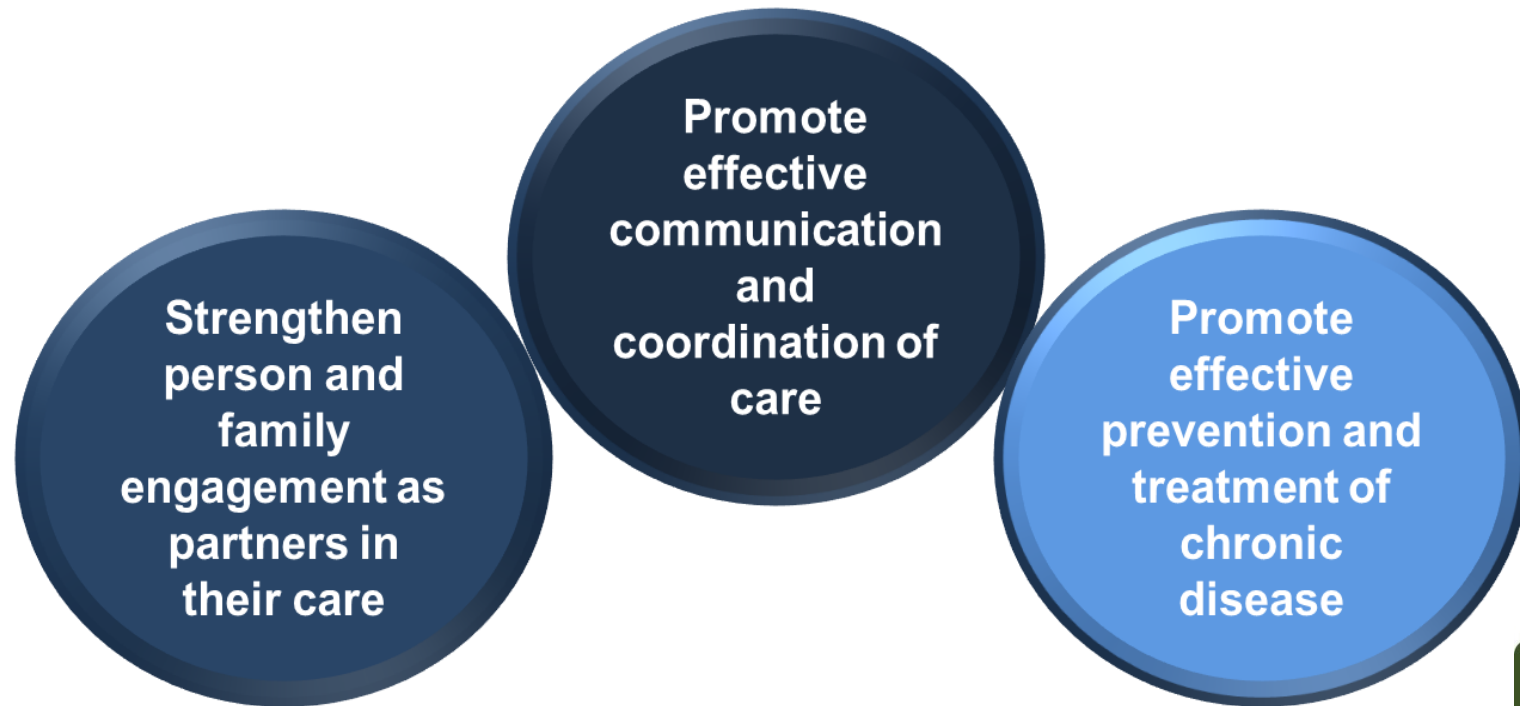
**Work with  
communities to  
promote best practices  
of healthy living**

**Make care affordable**

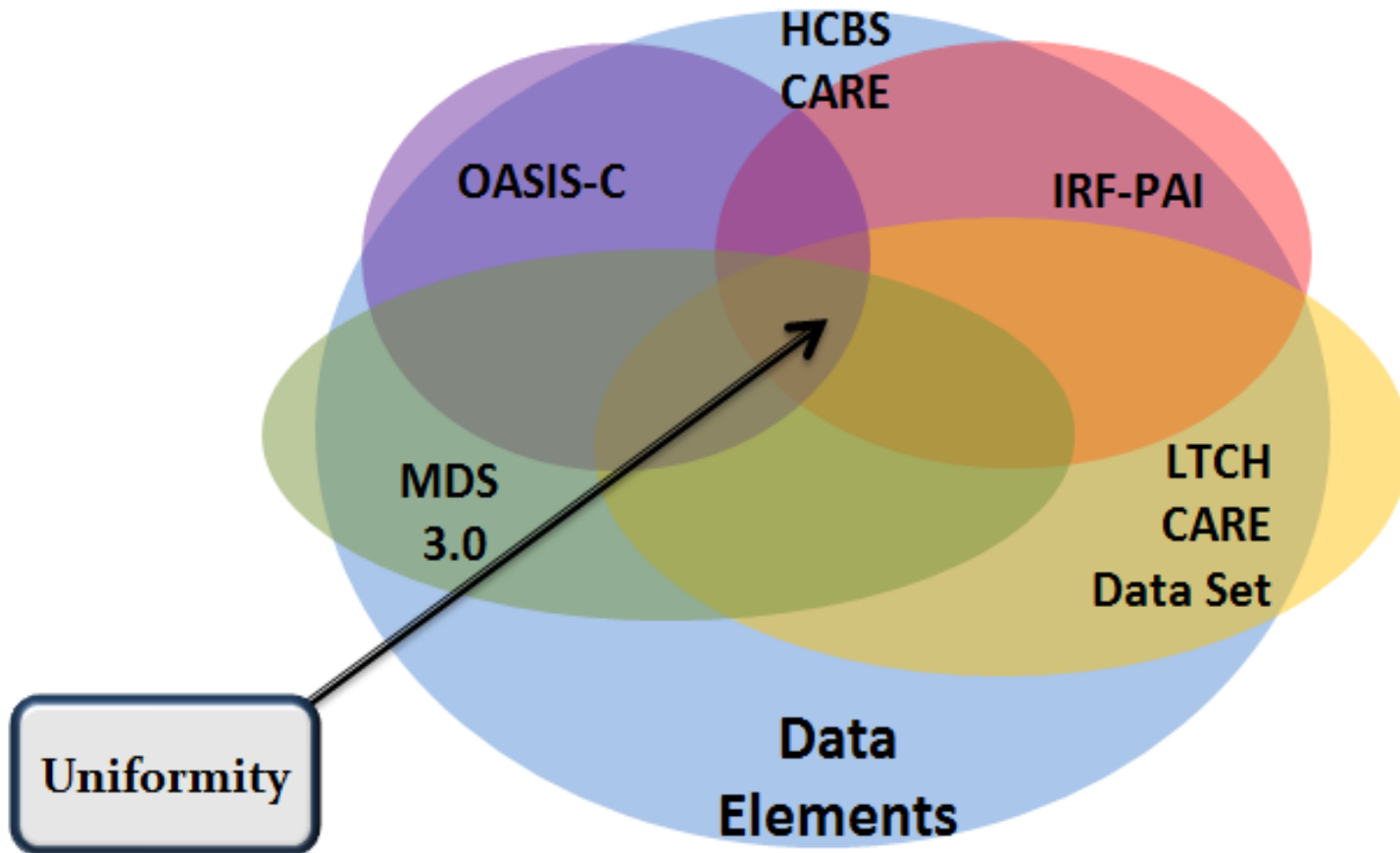
# Addressing Critical Gaps

## The IMPACT Act & Opportunity

The Act provides an opportunity to address all as well as the most challenging goals within the CMS Quality Strategy:

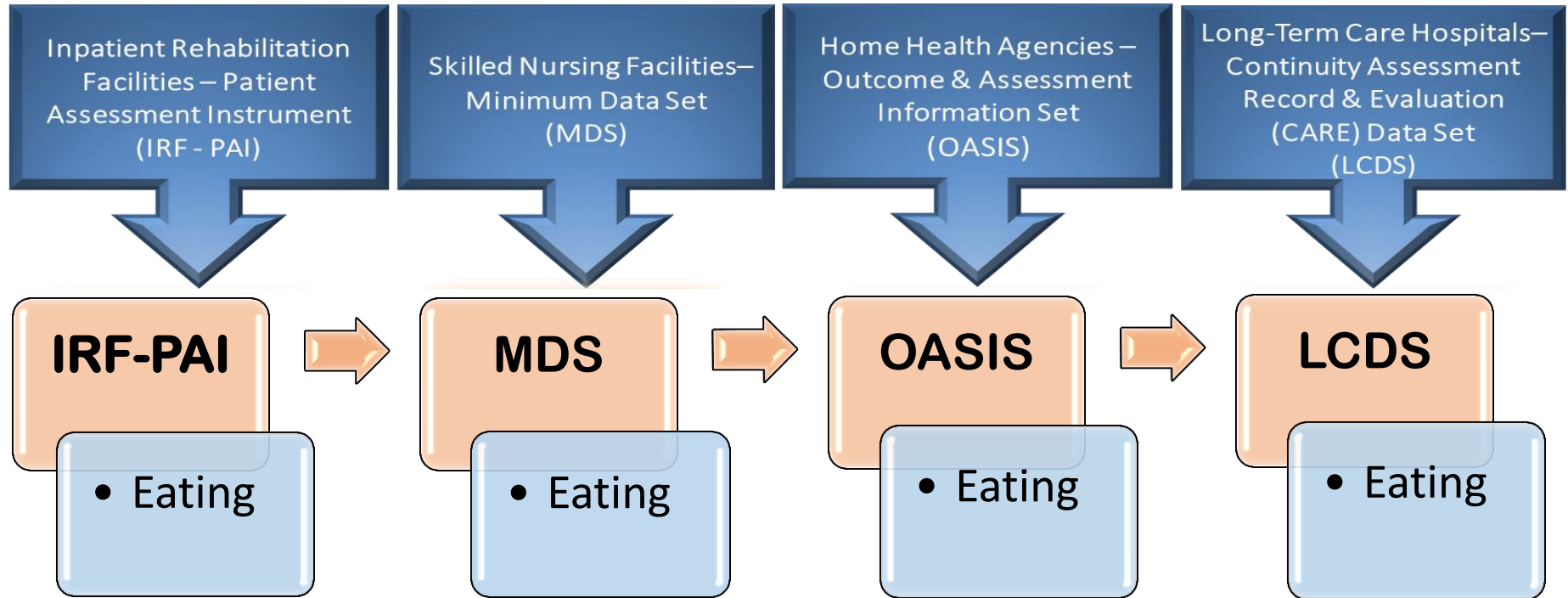


# Data Elements: Standardization



# What is Standardization?

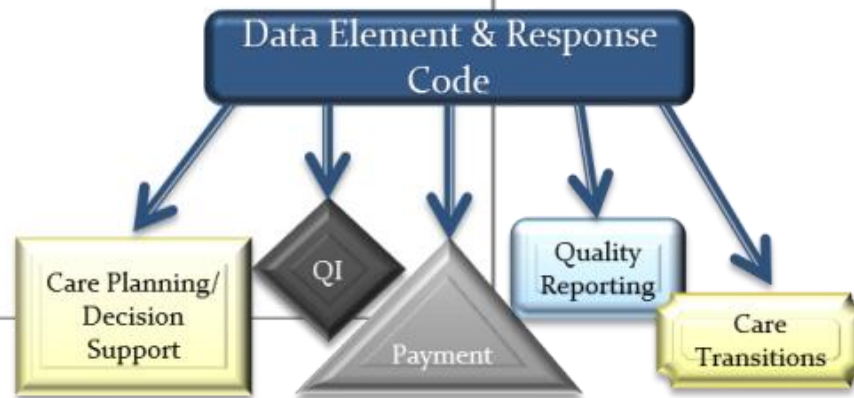
## Standardizing Function at the Item Level



# Standardized Assessment Data Elements

One Question: Much to Say → One Response: Many Uses

GG0160. Functional Mobility (Complete during the 3-day assessment period.)										
Code the patient's usual performance using the 6-point scale below.										
<b>CODING:</b> <b>Safety and Quality of Performance</b> - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. <i>Activities may be completed with or without assistive devices.</i> 06. <b>Independent</b> - Patient completes the activity by him/herself with no assistance from a helper. 05. <b>Setup or clean-up assistance</b> - Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity. 04. <b>Supervision or touching assistance</b> - Helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03. <b>Partial/moderate assistance</b> - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02. <b>Substantial/maximal assistance</b> - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. <b>Dependent</b> - Helper does ALL of the effort. Patient does none of the effort to complete the task.  07. <b>Patient refused</b> 09. <b>Not applicable</b> If activity was not attempted, code: 88. Not attempted due to medical condition or safety concerns	<b>Enter Codes in Boxes</b> <table border="1"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td>A. <b>Roll left and right:</b> The ability to roll from lying on back to left and right side, and roll back to back.</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td>B. <b>Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed.</td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td>C. <b>Lying to Sitting on Side of Bed:</b> 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.</td> </tr> </table>	<input type="text"/>	<input type="text"/>	A. <b>Roll left and right:</b> The ability to roll from lying on back to left and right side, and roll back to back.	<input type="text"/>	<input type="text"/>	B. <b>Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed.	<input type="text"/>	<input type="text"/>	C. <b>Lying to Sitting on Side of Bed:</b> 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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# Opportunities In the Ideal State

- Real time use of standardized and interoperable data to transform health care services through care coordination on time clinical decision support, and provider-level quality improvement
- Enable and support information/data to follow the person across health care and home and community-based services
- **Support transformation from a fragmented post-acute care delivery and payment system to a patient-centered system**



# Overarching Principles

**The Mission:** To transform and modernize the health care system; promoting effective, efficient, high quality care for beneficiaries, through the use of standardized, reusable data so as to:

- Facilitate rapid, accurate exchange of critical patient information to reduce errors, prevent adverse events and improve care
- Allow for the measurement and reporting of comparable quality across providers and provider types
- Enable person-centered decision making using comparable data
- Enable payment reform



# Guiding Principles I

We believe that certain principles should be applied in the work related to data standardization and that the data should:

- Allow for reusable data:
  - Data to serve multiple purposes: **collect once**, use multiple times
- Create a common spoken and IT language
  - Enable interoperability
  - Facilitate care coordination through standardized communication
- Be usable across the continuum of care, and beyond the healthcare system



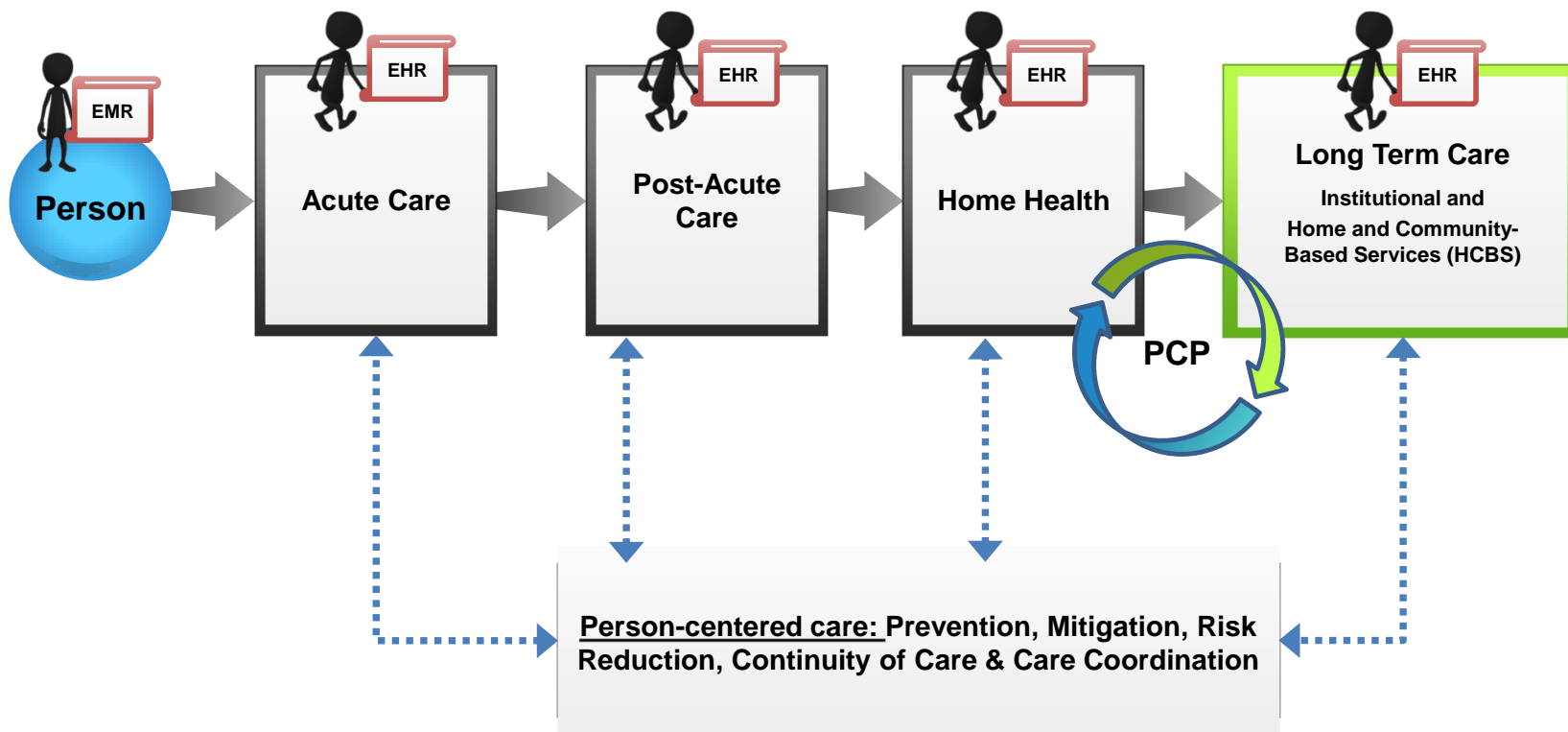
# Guiding Principles II

Assessment instrument item development shall take into account these essential principles:

- The data elements selected for use shall reside in the public domain
- Item development shall occur through a consensus-based development process
- Application of current science
- Adherence to the statutory requirements under the IMPACT Act of 2014



# Standardization: Ideal State

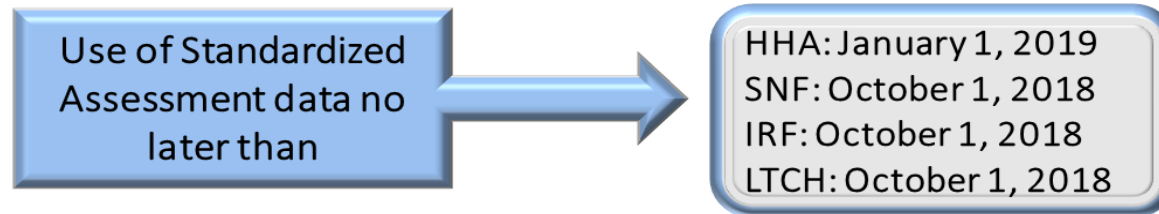


*Information Follows the Person*

# 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



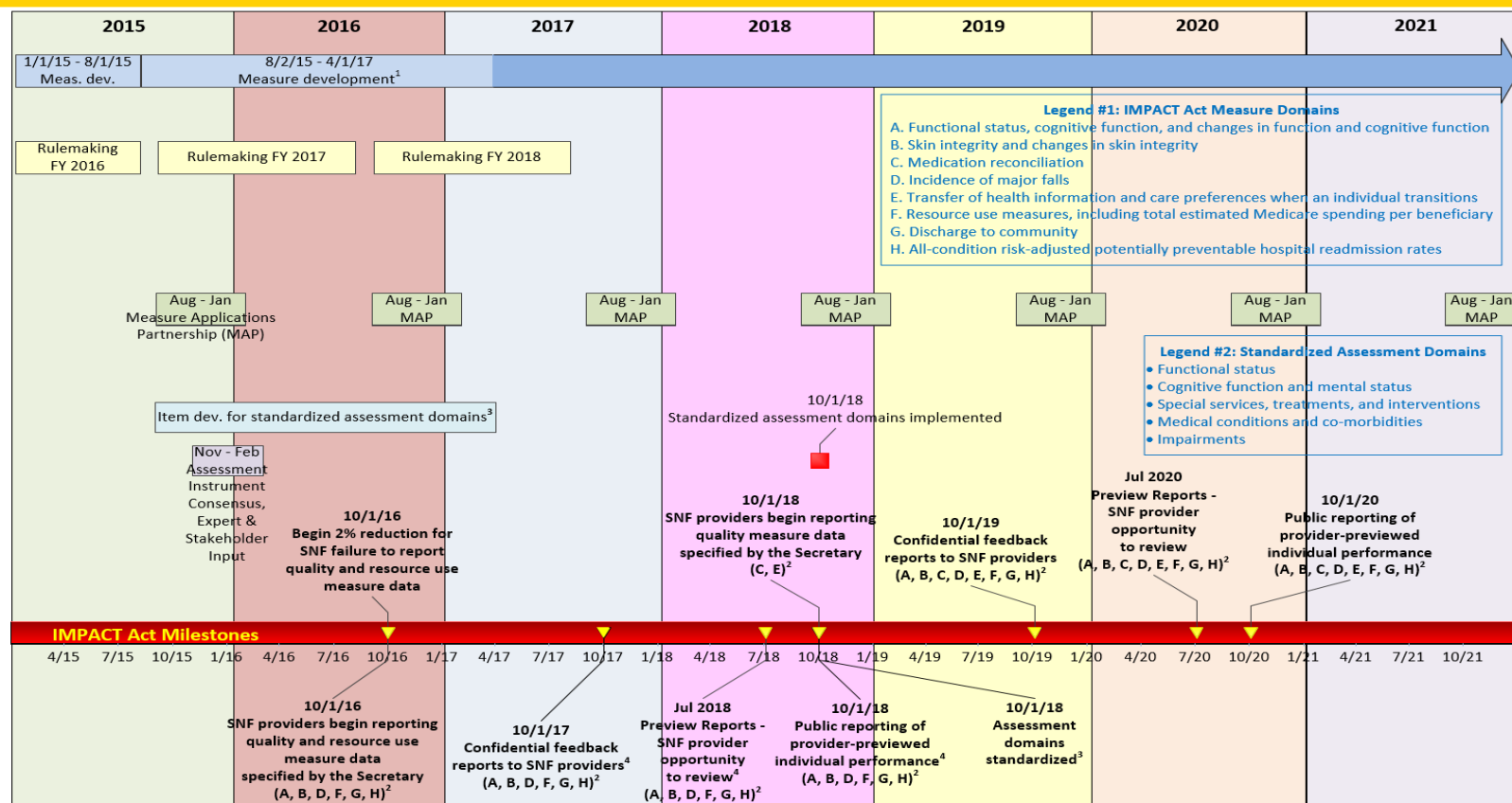
- The data must be submitted with respect to admission and discharge for each patient, or more frequently as required

- **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



# PAC QRP SNF Estimated Timelines/Milestones to Meet the IMPACT Act of 2014 Timeline Requirements



<sup>1</sup> Quality measure development requires six months to two years and includes public input, stakeholder input, and the MAP process

<sup>2</sup> IMPACT Act measure domains are defined in legend #1 above

<sup>3</sup> IMPACT Act assessment domains are defined in legend #2 above

<sup>4</sup> Provider feedback and preview reports and publicly reported data are refreshed at regular intervals after starting



# SNF Quality Reporting Program

- In response to the reporting requirements under the Act, CMS established the SNF Quality Reporting Program (QRP) and its quality reporting requirements in the FY 2016 SNF PPS.
- Per the statute, SNFs that do not submit the required quality measures data may receive a two percentage point reduction to their annual payment update (APU) for the applicable payment year.
- For more information regarding the SNF QRP, please visit our page under construction:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html>



# SNF Quality Reporting Program

## Overview Quality Measures Overview

- CMS has adopted three quality measures for the SNF QRP that will be collected beginning on October 1, 2016 for FY 2018 and subsequent annual payment update determinations.
- All three of these quality measures use assessment data from the MDS.
- Please refer to Centers for Medicare & Medicaid Services 42 CFR Part 483 Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs) for FY 2016, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and Staffing Data Collection; Final Rule <https://federalregister.gov/a/2015-18950>



# SNF Quality Reporting Program Policy Overview

## SNF QRP Policies Finalized in the 2016 PPS/SNF QRP Final Rule discussed in this presentation:

- g. Form, Manner, and Timing of Quality Data Submission
  - (1) Participation/Timing for New SNFs
  - (2) Data Collection Timelines and Requirements for the FY 2018 Payment Determination and Subsequent Years
- h. SNF QRP Data Completion Thresholds for FY 2018 Payment Determination and Subsequent Years



# SNF Quality Reporting Program Policy Overview (continued)

## SNF QRP Policies Finalized in the 2016 PPS/SNF QRP Final Rule discussed in this presentation:

- j. SNF QRP Submission Exception and Extension Requirements for the FY 2018 Payment Determination and Subsequent Years
- k. SNF QRP Reconsideration and Appeals Procedures for the FY 2018 Payment Determination and Subsequent Years
- l. Public Display of Quality Measure Data for the SNF QRP



# SNF Quality Reporting Program Overview

## g. Form, Manner, and Timing of Quality Data Submission

### (1) Participation/Timing for New SNFs.

- A new SNF would be required to begin reporting data on any quality measures finalized for that program year by no later than the first day of the calendar quarter subsequent to 30 days after the date on its CMS Certification Number (CCN) notification letter.
- For example, for FY 2018 payment determinations, if a SNF received its CCN on August 28, 2016, and 30 days are added (for example, August 28 + 30 days = September 27), the SNF would be required to submit data for residents who are admitted beginning on October 1, 2016.





# **SNF Quality Reporting Program Overview**

## **g. Form, Manner, and Timing of Quality Data Submission**

### **(continued)**

### **(2) Data Collection Timelines and Requirements for the FY 2018 Payment Determination and Subsequent Years**

- FY 2018 payment determination:
- CMS will collect data on residents who are admitted to the SNF on and after October 1, 2016, and discharged from the SNF up to and including December 31, 2016.



# SNF Quality Reporting Program Overview

## g. Form, Manner, and Timing of Quality Data Submission (continued)

### Data Collection Timelines and Requirements for the FY 2018 Payment Determination (cont.)

We are collecting a single quarter of data for FY 2018 APU determination in order to:

- Remain consistent with the usual October release schedule for the MDS;
- To give SNFs a sufficient amount of time to update their systems so that they can comply with the new data reporting requirements; and
- To give CMS a sufficient amount of time to determine compliance for the FY 2018 program.

The proposed use of one quarter of data for the initial year of quality reporting is consistent with the approach we used to implement a number of other QRPs, including the LTCH, IRF, and Hospice QRPs.



# SNF Quality Reporting Program Overview

## h. SNF QRP Data Completion Thresholds for the FY 2018 Payment Determination and Subsequent Years

- Beginning with the FY 2018 payment determination, SNFs must report all of the data necessary to calculate the quality measures on at least 80 percent of the MDS assessments that they submit.
- A SNF is compliant with the QRP if all of the data necessary to calculate the measures has been submitted to fully calculate the quality measures.
- A measure cannot be calculated, for example, when the use of a dash [-], indicates that the SNF was unable to perform a pressure ulcer assessment.



# SNF Quality Reporting Program Overview

## j. SNF QRP Submission Exception and Extension Requirements for the FY 2018 Payment Determination and Subsequent Years

- Our experience with other QRPs has shown that there are times when providers are unable to submit quality data due to extraordinary circumstances beyond their control (for example, natural, or man-made disasters).
- A SNF may request an exception or extension for the SNF QRP within 90 days of the date that the extraordinary circumstances occurred.



# SNF Quality Reporting Program Overview

## j. SNF QRP Submission Exception and Extension Requirements for the FY 2018 Payment Determination and Subsequent Years (Continued)

- The SNF may request an exception or extension for one or more quarters by submitting a written request to CMS that contains the information noted below, via email to the SNF Exception and Extension mailbox. This mailbox will be activated when the QRP is implemented:  
[SNFQRPreconsiderations@cms.hhs.gov](mailto:SNFQRPreconsiderations@cms.hhs.gov).
- Requests sent to CMS through any other channel will not be considered as valid requests for an exception or extension from the SNF QRP's reporting requirements for any payment determination.



# SNF Quality Reporting Program Overview

## k. SNF QRP Reconsideration and Appeals Procedures for the FY 2018 Payment Determination and Subsequent Years

Beginning with the FY 2018 payment determination and subsequent years, a SNF would receive a notification of noncompliance if CMS determines that the SNF failed to submit data in accordance with the data reporting requirements with respect to the applicable FY. The purpose of this notification is to put the SNF on notice of the following:





# SNF Quality Reporting Program Overview

## k. SNF QRP Reconsideration and Appeals Procedures for the FY 2018 Payment Determination and Subsequent Years (continued)

- 1) that the SNF has been identified as being non-compliant with the SNF QRP's reporting requirements for the applicable FY;
- 2) that the SNF will be scheduled to receive a reduction in the amount of two percentage points to its market basket percentage update for the applicable FY;
- 3) that the SNF may file a request for reconsideration if it believes that the finding of noncompliance is erroneous, has submitted a request for an extension or exception that has not yet been decided, or has been granted an extension or exception; and
- 4) that the SNF must follow a defined process on how to file a request for reconsideration, which will be described in the notification. We would only consider requests for reconsideration after a SNF has been found to be noncompliant.



# SNF Quality Reporting Program Overview

## I. Public Display of Quality Measure Data for the SNF QRP

- Public reporting of SNF QRP quality data is scheduled to begin in fall 2018 as per the IMPACT Act, Section 1899B(g)(1).
- Public reporting will include a period for review and correction of quality data prior to the public display of SNF performance data, which will initially include data on the 3 quality measures addressed in this presentation.



## Check Your Understanding:

**If a dash [-] is used to code an MDS item that is included in the calculation of a quality measure, that item cannot be used in the calculation of the measure.**

1. True
2. False



## **Check Your Understanding:**

**Beginning with the FY 2018 payment determination, SNFs must report all of the data necessary to calculate the quality measures on at least 80 percent of the MDS assessments that they submit.**

1. True
2. False



## Check Your Understanding:

**If a SNF provider is unable to submit quality data due to extraordinary circumstances beyond their control (for example, natural, or man-made disasters), they may request an exception or extension.**

1. True
2. False



## **Check Your Understanding:**

**A SNF may request an exception or extension for the SNF QRP within 120 days of the date that the extraordinary circumstances occurred.**

1. True
2. False



# Announcements

- Please watch CMS.gov for announcements regarding provider outreach in advance of the October 1<sup>st</sup> implementation of the SNF QRP.
- Questions may be submitted by email to: [SNFQualityQuestions@cms.hhs.gov](mailto:SNFQualityQuestions@cms.hhs.gov).



# Questions and Answers

