The House Ways and Means and Senate Finance Committees have released draft legislation “designed to strengthen Medicare’s post-acute care (PAC) services.” The legislation if enacted would require post-acute care (PAC) and other providers to report standardized patient assessment data, standardized quality measures, and resource use measures to allow for comparison of such data across all such providers. The draft defines PAC providers as: 1) home health agencies (HHA); 2) skilled nursing facilities (SNF); 3) inpatient rehabilitation facilities (IRF); and 4) long-term care hospitals (LTCH).


According to a press release accompanying the draft, that the impact and purpose of the legislation would enable Medicare to:

1. Compare quality across PAC settings;
2. Improve hospital and PAC discharge planning; and,
3. Use this information to reform PAC payments (via site neutral or bundled payments or some other reform) while ensuring continued beneficiary access to the most appropriate setting of care.

Comment

No doubt, this is but another step trying to reshape Medicare’s payments for post acute care services. Bundling and site neutral payments appear inevitable. The question is when?

From the provider perspective thoughts and financial analysis need to be undertaken to access any coming changes. It can still be many years before Medicare adopts these concepts, but owning, divesting or acquiring PAC services is not accomplished overnight.

Knowing one’s cost of providing such services is paramount to any decision-making. The time to understand the financial aspects should begin as soon as possible.
The following material is from the section-by-section bill summary:

**Requirement for Standardized Assessment Data**

Amends title XVIII of the Social Security Act (SSA) to add a new section 1899B.

**Definition of PAC Assessment Instruments**

Defines PAC assessment instruments as: 1) Outcome and Assessment Information Set (OASIS); 2) the Minimum Data Set (MDS); 3) the IRF-Patient Assessment Instrument (IRF-PAI); and 4) LTCH-Continuity Assessment and Record Evaluation (LTCH-CARE).

**Standardized Patient Assessment Data**

Requires PAC providers to report standardized patient assessment data under the requirements of the applicable reporting provisions by October 1, 2018, for SNF, IRF and LTCH and January 1, 2019 for HHA. At a minimum, the Secretary shall require reporting at times of admission and discharge. The standardized patient assessment data shall include functional status, cognitive function, special services, medical condition, impairments, prior functioning levels, and any other categories as stated by the Secretary to be necessary and appropriate.

**Patient Assessment Data Requirement for Inpatient Hospitals**

Requires inpatient hospitals, critical access hospitals and PPS-exempt cancer hospitals to submit standardized patient assessment data by October 1, 2018. Standardized patient assessment data shall be submitted no less than one time per admission and shall include medical condition, functional status, cognitive function, living situation, access to care at home, and any other indicators necessary for assessing patient need. After two years of assessments, the Secretary shall report to Congress on the inpatient assessments and make recommendations for any changes.

**Alignment with Medicare Part B Therapy Data**

The Secretary shall standardize all patient assessment data with the patient assessment data collected for outpatient therapy services under Medicare Part B.

**Requirement for New Quality Measures**

By October 1, 2016 for SNF, IRF and LTCH and January 1, 2017 for HHA, the Secretary shall specify additional quality measures that PAC providers are required to submit under the applicable reporting provisions. The measures shall address, at a minimum, the following quality domains: 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.

**Requirement for Resource Use Measures**

By October 1, 2016, 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 resource use domains: 1) **efficiency measures to include total Medicare spending per beneficiary (emphasis added)**; 2) discharge to community; and 3) risk adjusted hospitalization rates of potentially preventable admissions and readmissions.

**Adjustments for the Medicare Spending per Beneficiary Resource Use Measure**

The Secretary shall adjust the measure in the same manner as in the hospital value-based purchasing program and standardize the measure for geographic payment rate differences and payment differentials consistent with the hospital value-based purchasing methodology. In addition, the Secretary
shall consider aligning the measure with respect to episode length in a similar way to what is used for the Medicare spending per beneficiary measure under hospital value-based purchasing. Finally, the Secretary shall consider making adjustments based on studies required under the bill, regarding socioeconomic status and other factors, to the quality and resource use measures.

**Payment Consequences Under the Applicable Reporting Provisions**

Creates payment consequences for failure to report standardized assessment data, quality, resource and other measures for PAC providers, and consequences for other providers for failure to report assessment data.

Requires HHA submission of quality and resource use measures beginning Calendar Year (CY) 2017 under the applicable reporting program. Requires HHA submission of standardized patient assessment data beginning CY 2019 under the applicable reporting program.

Requires SNF, IRF and LTCH submission of quality and resource use measures beginning Fiscal Year (FY) 2017 under the applicable reporting program. Requires SNF, IRF and LTCH submission of standardized patient assessment data beginning FY 2019.

Establishes a new “SNF Quality Reporting Program” at the start of fiscal year 2019. The Secretary shall reduce the annual SNF market basket update by 2 percentage points for those SNFs that fail to report quality measures or assessment data under the SNF Quality Reporting program. The application of a penalty due to failure to report quality measures is allowed to result in a market basket update less than zero. Standardized patient assessment data is required under the new SNF Quality Reporting Program.

For CAHs, a new “CAH Quality Reporting Program” is established with payments reduced by two percentage points for failure to report standardized patient assessment data, consistent with the pay-for-reporting requirements for inpatient hospitals paid under the prospective payment system and post-acute providers. For PPS-exempt cancer hospitals, the Secretary shall reduce the annual market basket update by two percentage points for failure to report standardized patient assessment data.