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The History & Status of the IMPACT Act

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Medicare Policy Brief

The History & Status
of the IMPACT Act

Professor Lisa M. Grabert

February 2021
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Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

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Provides an executive summary of the policy brief, as well as a comprehensive list of the 7 key recommendations policymakers should consider in order to successfully achieve the vision set forth by the IMPACT Act.

Background on Post-Acute Care (PAC)
Includes background on the four PAC settings, including total Medicare spend, characteristics of the different providers and similarity of patient populations.

Building the Foundation for the IMPACT Act
Covers the Congressional intent behind the bill, feedback from public as the bill was being developed, high-level overview of the goals and the pathway to enactment.

Goals of the IMPACT Act
Summarizes, in-depth, each of the seven IMPACT Act goals. In addition to describing each goal, this section also includes a status update on the goal’s implementation.

Home Health (HH) and Skilled Nursing Facility (SNF) Payment Reform
Reviews the HH and SNF payment reform that CMS implemented at the same time it was implementing the IMPACT Act requirements.

COVID-19 Public Health Emergency (PHE)
Highlights the significant impact the COVID-19 PHE has had on Medicare beneficiaries and PAC providers.

Recent Congressional Developments
Covers the most recent Congressional actions regarding the IMPACT Act and its implementation.

Executive Summary

The ability to effectively study and compare Medicare patients—and the cost and outcomes associated with their care—has long been, and continues to be limited, by the lack of readily comparable, patient-level, clinical data. This is due primarily to Medicare’s reliance and use of historically-developed, and limited administrative data—data derived from traditional insurance claims records, not patient treatment records. Critics of this situation have long called for the development of more comprehensive patient-level and clinically focused data, particularly in support of increasing efforts to compare and promote higher quality of care in the system.

Calls to develop more comprehensive patient outcome data in the post-acute care (PAC) sector led Congress to mandate the development of a common patient assessment tool and the enactment of legislation—the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. This policy brief explores the intent and goals behind IMPACT, progress on the completion of IMPACT requirements, and the implications stemming from the implementation of IMPACT. In addition, the brief explores the effect the COVID-19 Public Health Emergency and recent payment reforms has had on IMPACT—two important factors that were not anticipated when IMPACT was contemplated.

The policy brief concludes with a review of current legislative actions pertaining to IMPACT—a recent bipartisan oversight letter from 17 U.S. Senators and a bill resetting the IMPACT timeline introduced by several members of the U.S. House of Representatives. This brief is meant to aide policymakers and other interested parties as they weigh whether it is still possible to achieve IMPACT’s original intent to compare and possibly substitute the services rendered to similar patients treated at different PAC provider venues.
Recommendations

#1 The Medicare Payment Advisory Commission (MedPAC) should publicly release the list of diagnostic conditions it has concluded significantly overlap across PAC settings. The list should compare setting-by-setting, such as rehab hospitals compared to skilled nursing facilities.

#2 The Center for Medicare & Medicaid Services (CMS) should review all Standardized Patient Assessment Data Elements (SPADES) requirements to ensure each data element is needed either for reimbursement or quality measurement. Those elements that do no meet these purposes should not longer be required. The MedPAC should use both SPADES and administrative billing data when considering payment reform options.

#3 The Congress should authorize a unified post-acute care value-based purchasing program. The payment withhold should be significant enough to change provider behavior.

#4 The Congress should pursue oversight activities, such as legislative hearings, to determine why CMS has not completed the clinical and financial data linking required by the IMPACT Act.

#5 The Congress should require inpatient acute care hospitals to report SPADES, such as those required of PAC providers.

#6 Both CMS and MedPAC should test a variety of potential units of reimbursement, including a clinical grouping (such as diagnosis-related groups) and a per diem payment.

#7 Congress should pursue regular order on H.R. 8826 and it should be signed into law—delaying the IMPACT Act timeline for a minimum of 5-years.

Medicare Post-Acute Care Defined

On an annual basis, approximately $60 billion taxpayer dollars are spent to deliver services to Medicare patients in 4 unique post-acute care settings.

These healthcare settings have a long-standing history.

Long-Term Care and Rehabilitation hospitals were recognized as distinct (separate from acute care) facilities in 1983.

Skilled Nursing Facilities and Home Health were recognized as unique care settings when Medicare was established in 1965.
Key Differences and Similarities

Each of the 4 settings of care are clearly defined by the Federal Government and represent unique abilities to care for patients.

Long-Term Care and Rehabilitation Hospitals are held to highest standards of care.

Both Skilled Nursing Facilities and Home Health Agencies have more relaxed care standards, compared to Hospitals.

Characteristics of Pose-Acute Care Settings

<table>
<thead>
<tr>
<th></th>
<th>Typical Patient</th>
<th>Physician Services</th>
<th>Nursing Services</th>
<th>Therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTCH</td>
<td></td>
<td></td>
<td></td>
<td>PT/OT/SLP onsite*</td>
</tr>
<tr>
<td>IRF</td>
<td>Traumatic Brain Injury</td>
<td>3 Times Per Week</td>
<td>Medium Nurse-to-Patient Ratio</td>
<td>PT/OT/SLP onsite</td>
</tr>
<tr>
<td>SNF</td>
<td>Prior 3-Day Hospital Stay</td>
<td>Every 60 Days</td>
<td>Low Nurse-to-Patient Ratio</td>
<td>Physician Order, may not be on site</td>
</tr>
<tr>
<td>HHA</td>
<td>Homebound</td>
<td>Once—90 Days Before Episode, or 30 Days after</td>
<td>Nurse Visit Required</td>
<td>Physician Order, may not be on site</td>
</tr>
</tbody>
</table>

*PT—physical therapy, OT—occupational therapy, SLP—speech language pathology and RT—respiratory therapy

Overlapping Patient Populations

Despite the differences, researchers have observed that similar patients are treated in each of the settings.

As illustrated on the bar chart, patient severity is not equal across all care settings.

Long-Term Care Hospitals are an outlier on this metric.

Some policymakers have questioned the value of patient overlap in the care options available to patients.

As illustrated on the scatterplot, Home Health patients have a much greater level of heterogeneity as compared to the other settings.

The concept of overlapping patient populations has been extensively studied by the Medicare Payment Advisory Commission (MedPAC).

However, MedPAC’s detailed analysis has not been made publicly available.

Source: American Hospital Association

Source: Post Acute Payment Reform Demonstration Report to Congress
Recommendation #1

The MedPAC should publicly release the list of diagnostic conditions it has concluded significantly overlap across PAC settings.

The list should compare setting-by-setting, such as rehab hospitals compared to skilled nursing facilities.
Those seven themes became the goals of the legislation:

1. Standardize and make public data reflecting patient function, cognition, special services, medical conditions and impairments.
2. Establish new quality and cost measures that are common across the 4 post-acute settings of care.
3. Publicly report the quality and cost measures to empower decision making.
4. Link patient-level clinical data with financial data.
5. Improve discharge planning from inpatient acute hospitals.
6. Create a strategic plan for unifying reimbursement for the 4 post-acute care settings.
7. Layout a 10-year vision of reform that affords patients, providers and tax-payers transparency and incremental change.

Historic, Stand-Alone Medicare Bill

The legislation was entitled The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

The IMPACT Act was voice voted in the U.S. House, passed by unanimous consent in the U.S. Senate, and signed into law by the President on October 6, 2014.

Over 160 health care organizations supported the IMPACT Act.

NOTE

In this policy brief, goals will be covered in the order they appeared in the legislation, not when they appear on this timeline.
The first goal of the IMPACT Act was to standardize and make public, data reflecting patient: function, cognition, special services, medical conditions and impairments.

Post-acute providers were required to submit patient assessment items (clinical data) on each Medicare patient treated—where the number of data elements ranged from 51 to 412, before IMPACT was signed into law.

This patient assessment data is the most comprehensive clinical data CMS collects from providers—the data requirements for acute hospitals and physicians are not as extensive.

Despite IMPACT’s requirement to avoid duplication or overlap of patient assessment items, CMS’s implementation of the new Standardized Patient Assessment Data Elements (SPADES) increased the number of patient assessment items—ranging from a 1.2-fold increase to a 3.9-fold increase.

For its mandate, MedPAC has been assessing the progression of the SPADES development. MedPAC has concluded that the SPADES are too dependent on provider reporting and therefore should not be used for purposes of payment reform. In lieu of SPADES, MedPAC is using administrative billing data.
Pursuit of Outcomes Measures

The second goal of the IMPACT Act was to create a common, parsimonious set of quality and cost measures across the 4 unique post-acute care settings.

The IMPACT Act established 9 core measures.

As of the date of publication of this policy brief, 8 of the 9 measures have been implemented.

The transformation of health information measure has been delayed so that providers are able to concentrate efforts on combating the COVID-19 Public Health Emergency.

Recommendation #2

The CMS should review all SPADES requirements to ensure each data element is needed either for reimbursement or quality measurement. Those elements that do not meet these purposes should no longer be required.

The MedPAC should use both SPADES and administrative billing data when considering payment reform options.
The third goal of the IMPACT Act was to empower patients by making the quality and cost measure results publicly available.

The general public can access the quality and cost information on a variety of Medicare “Compare” websites.

**Empowering Patients**

For example, a perspective patient can compare the performance of different rehabilitation hospitals on how likely it is the hospital will discharge home after the stay.

**Comparison of Rehabilitation Hospitals in the Milwaukee, Wisconsin Metro Area**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Rate of successful return to home and community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aurora Health Care Metro Inc.</td>
<td>66.6% No different than national rate.</td>
</tr>
<tr>
<td>Ascension Sacred Heart</td>
<td>59.4% No different than national rate.</td>
</tr>
<tr>
<td>Froedtert Memorial Lutheran</td>
<td>64.5% No different than national rate.</td>
</tr>
</tbody>
</table>

Beyond public reporting, the IMPACT quality and cost measures can also be used in value-based purchasing programs, like those in place for acute hospitals and physicians.

These value-based programs assess provider performance at the facility-level and allow for financial recognition of top national performance.

**Recommendation #3**

The Congress should mandate a unified Post-Acute Care Value-Based Purchasing (PAC VBP) program.

The (PAC VBP) payment withhold should be significant enough to change provider behavior.
The fourth goal of the *IMPACT Act* was to link an individual patient’s clinical data with that same patient’s financial or billing data.

*IMPACT* required this data matching for each of the annual 7.5 million Medicare post-acute care patients.

This patient-level data can be used to make modifications to the reimbursement of individual services, such as an episode of care for home health.

Without patient level linkage of clinical and financial information policy makers are unable to accurately and reliably alter the current PAC reimbursement schemes. Despite the importance of this data linkage, CMS has not made its progress towards this critical milestone available to the public.

The Congress should pursue oversight activities, such as legislative hearings, to determine why CMS has not completed the clinical and financial data linking required by the *IMPACT Act*. 
The fifth goal of the IMPACT Act was to require better coordination around transitions of care—particularly around discharge planning.

IMPACT required modification to the so-called Medicare & Medicaid ‘Conditions of Participation’ to achieve improved discharge planning.

The Conditions of Participation are a list of minimum requirements that most provider-types must comply with in order to care for Medicare and Medicaid patients.

Though IMPACT placed several new reporting requirements on PAC providers, it did not place similar requirements on inpatient acute hospitals—one of the most critical settings for care transitions.

Recommendation #5

The Congress should require inpatient acute care hospitals to report SPADES, similar to those required of PAC providers.
The sixth goal of the IMPACT Act was to craft a unified reimbursement plan across the 4 post-acute care settings.

Congress required plans from both CMS and MedPAC.

Congress explicitly did not authorize implementation of the plan.

**Recommendation #6**

Both CMS and MedPAC should test a variety of potential units of reimbursement, including a clinical grouping (such as the diagnosis-related groups) and a per diem payment.
In pursuit of its Unified Reimbursement Plan, CMS has utilized a Technical Expert Panel (TEP).

The CMS TEP is focusing on one unit of reimbursement for post-acute care.

Some provider groups have suggested that hospitals are too different than nursing homes and home health and therefore should be “carved-out.”

These provider groups point to the Medicare & Medicaid Conditions of Participation as evidence of the differences—where hospital requirements are much more extensive, burdensome and costly.

In pursuit of its Unified Reimbursement Plan, MedPAC has focused on the issue of overlap—specifically overlap among nursing home and rehab hospital patients.

Across several months of discussion, MedPAC Commissioners have voiced concern over how different care is in home health and long-term care hospitals—suggesting those settings may not be appropriate for unified payment.

Yet, other researchers have argued in favor of unification across the two hospitals types with a separate unification across the non-hospital types.

These many options represent the lack of consensus on the best way forward and emphasize the need for more research and analysis across these settings of care.
10-Year Strategic Plan

The seventh and final goal of the *IMPACT Act* was to create a 10-year strategic plan.

Congress crafted the strategic plan in such a way that each goal in *IMPACT* was meant to build from the previous goal.

The overall success of the *IMPACT Act* must be judged on the timing and outcome of each of its individual goals.

Congress required CMS to complete the discharge planning goal in 2016 but CMS issued the final regulation in 2019.

Congress required CMS to complete the clinical and financial data linking goal by 2019 but CMS has been silent and has not released any updates.

Competing Priorities

While CMS was implementing the Congressional *IMPACT Act* requirements, it also began implementation of skilled nursing facility and home health payment reform.

Using its existing authority, CMS implemented skilled nursing facility payment reform for fiscal year (October 1) 2020.

As a mandate from Congress—after CMS’s initial proposal—CMS implemented home health payment reform on January 1, 2020.

Referred to as silo-based reforms, these changes were not originally envisioned by Congress and significantly altered the landscape of the 10-year strategic plan.
On October 1, 2019, CMS implemented comprehensive payment reform for skilled nursing facilities—the Patient Driven Payment Model (PDPM). One of the main goals of PDPM was to create a payment system that was not dependent on the volume of therapy provided to patients—rather to utilize a system that focuses reimbursement on what the patient needs.

PDPM recognizes different reimbursement for physical therapy and occupational therapy, speech language pathology, nursing and non-therapy ancillaries, such as drugs.

On January 1, 2020, CMS implemented comprehensive payment reform for home health agencies—the Patient Driven Groupings Model (PDGM). One of the main goals of PDGM was to recognize the differences in patient and resource needs of individuals receiving home health directly after an acute hospitalization versus those individuals receiving home health from the community—with the goal of avoiding a hospitalization.

PDGM also differentiates reimbursement based on whether the home health episode is "early" or the first episode a patient receives versus "late" or any episode beyond the initial.

PDGM reimburses on a 30-day episode of care—where prior to PDGM home health agencies were reimbursed on a 60-day episode of care.
Unprecedented Public Health Emergency

As of October 2020, the U.S. has had nearly 1.2 million cases of COVID-19 across the Medicare population.

In rural areas there were 1,254 Medicare COVID cases per 100,000 people.

In urban areas there were 2,002 Medicare COVID cases per 100,000 people.

Medicare Payments for Fee-for-Service COVID-19 Hospitalizations

$5.1 Billion

Total Medicare payment for fee-for-service COVID-19 hospitalizations

Source: Centers for Medicare & Medicaid Services

COVID-19 Disproportionately Impacts Medicare

As of October 2020, the U.S. has had nearly 333,000 hospitalizations of COVID-19 across the Medicare population.

In rural areas there were 334 Medicare COVID hospitalizations per 100,000 people.

In urban areas there were 567 Medicare COVID hospitalizations per 100,000 people.

Among those COVID Medicare patients who have been hospitalized, 22% were discharged to nursing homes and 14% were discharged with home health.

Combating the COVID-19 Public Health Emergency has been a significant challenge for every health care provider, especially post-acute care providers.

Source: Centers for Medicare & Medicaid Services
The confluence of: 1) COVID-19 Public Health Emergency; 2) skilled nursing facility and home health payment reform; and 3) delayed implementation of key IMPACT Act milestones has led policy makers to conclude IMPACT’s timeline should be delayed.

In recognition of these challenges, 17 U.S. Senators (led by Senators Tommey and Bennet) sent a bipartisan letter to CMS requesting a status update on each of the 46 deliverables in the IMPACT Act.

The letter stated “COVID-19 has placed a strain on the entire health care system, particularly affecting PAC patients, and we are concerned with the administration’s implementation of key IMPACT provisions.”

The letter also stated “key elements of the IMPACT Act are behind schedule or have not been implemented as Congress intended.”

House Representatives Craft a Solution

In addition to the Senate, key Members of the U.S. House of Representatives (led by Representatives Sewell, Pascrell and Suozzi) are also concerned about IMPACT’s timeline and have introduced H.R. 8826 (116th)—The Resetting the IMPACT Act of 2020.

The bill also requires the use of SPADES elements to meet the definition of clinical data and PDPM and PDGM data to meet the definition of financial data.

Finally, the bill prohibits the use of any data that has been collected during the COVID-19 Public Health Emergency.
Recommendation #7

Congress should pursue regular order on H.R. 8826 and it should be signed into law—delaying the IMPACT Act timeline for a minimum of 5-years.

Professor Lisa M. Grabert

Professor Grabert is research faculty in the College of Nursing at Marquette University in Milwaukee, WI. Lisa teaches a graduate health policy course and her research is focused on both Medicare reimbursement and COVID-19 issues.

Prior to her role as faculty, Lisa was a senior aide for the U.S. House of Representatives Committee on Ways and Means. She served under Chairman Kevin Brady (TX), Paul Ryan (WI) and Dave Camp (MI). In her capacity on Ways and Means Lisa had responsibility over the Medicare program.

Before Ways and Means, Lisa was a senior associate director of policy at the American Hospital Association (AHA). At the AHA Lisa worked with hospitals on quality and reimbursement issues.

Prior to the AHA, Lisa was a policy analyst at the Centers for Medicare & Medicaid Services (CMS). At CMS, Lisa regulated hospital and physician reimbursement and implemented national performance-based payment programs.

Lisa earned a Masters in Public Health, with an emphasis in Health Policy and Management from Emory University in Atlanta, GA and a Bachelors of Science degree with an emphasis in biochemistry and communication arts from the University of Wisconsin-Madison.