

# Coming to Terms With the IMPACT Act of 2014

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## MeSH TERMS

- health care reform
- home care agencies
- Medicare
- outcome and process assessment (health care)
- rehabilitation
- skilled nursing facilities

The Improving Medicare Post-Acute Transformation (IMPACT) Act of 2014 will set the course for much of postacute care well into the next decade. It (1) authorizes a uniform method of patient assessment in postacute care; (2) sets a timetable for developing, implementing, and reporting quality measures; and (3) lays the groundwork for future payment reform in postacute care. This article places the IMPACT Act into the larger arc of health care reform and change. It summarizes the law's key provisions and presents a contrarian analysis of this much-heralded bipartisan legislation. The Affordable Care Act (ACA) of 2010 already gives the Centers for Medicare and Medicaid Services the authority to implement what the IMPACT Act requires. The IMPACT Act may even slow down the changes envisioned in the ACA. The article concludes by noting the implications for occupational therapy both as a practice and a profession.

DeJong, G. (2016). Health Policy Perspectives—Coming to terms with the IMPACT Act of 2014. *American Journal of Occupational Therapy, 70*, 7003090010. <http://dx.doi.org/10.5014/ajot.2016.703003>



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The Improving Medicare Post-Acute Transformation Act of 2014 (IMPACT Act; Pub L. 113–185) is an unusual piece of legislation. It took a mere 40 days from its introduction to become public law and passed in a momentary flash of bipartisanship (Wagner, 2014). Although it had the support of the skilled nursing industry, it had no constituency clamoring for it, and it was not sought by the administration. In fact, it may not even have been needed. Yet, it will set the course for much of postacute care for the next several years.

In this article, I place the legislation into a larger context that will enable readers to better understand its individual provisions and what it means for the future of postacute care and its stakeholders, including the occupational therapy profession. By *context*, I mean the larger arc of health care reform and change now under way. The IMPACT Act focuses on the development and implementation of postacute quality measures and has a specific timetable for each of the four individual postacute settings: skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFS), long-term care hospitals (LTCHs), and home health agencies (HHAs). I argue that much of the legislation was not needed given what has already been put into

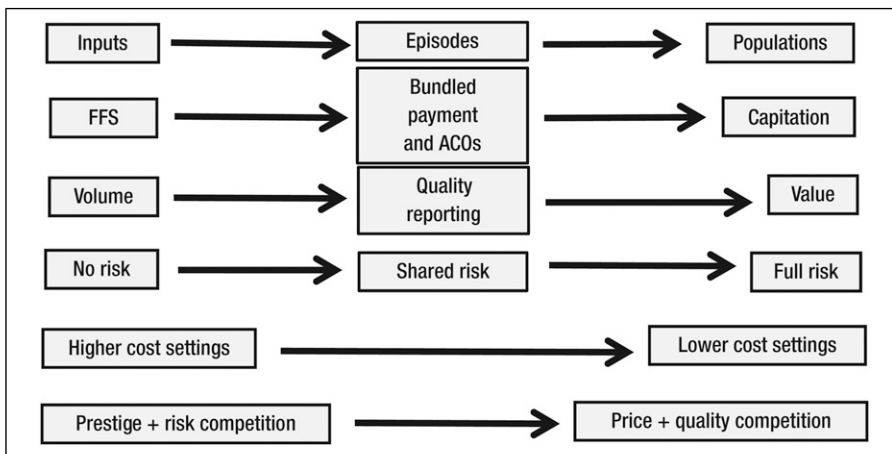
motion as a result of the Patient Protection and Affordable Care Act of 2010 (ACA; Pub. L. 111–148), the nation's health care reform law. I conclude by noting what the law means for the future of occupational therapy practice and for other postacute practitioners as well.

## Larger Changes Under Way in U.S. Health Care

The IMPACT Act requires some understanding of the larger changes under way in U.S. health care. Figure 1 provides a thumbnail sketch of where health care is moving. Historically, we (meaning patients and third parties) have paid for health care using fee-for-service methods, that is, payment for each input or unit of service. The more care that providers rendered, the more we paid. Clinical productivity was measured by the units of services rendered, or volume. Providers faced minimal financial risk for overtreatment or using more expensive care settings.

The United States is now in a transition period in which providers are gradually learning to manage episodes of care and entire populations for a fixed price. In this interim period, payers, such as Medicare, share financial risks with

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**Figure 1. Transitions in U.S. health care.**

Note. ACOs = accountable care organizations; FFS = fee for service.

providers on the basis of the extent to which providers meet price and quality targets. As health care evolves, providers will eventually take on greater risk, if not full risk, for entire populations and the episodes of care that occur within target patient populations.

Until now, health systems and hospitals have competed on the basis of reputation or prestige (e.g., their *U.S. News and World Report* ranking, level of specialization, use of latest technologies, academic affiliations, research prowess, faculty publications in prestigious journals, facility amenities), which we equated with quality. Health plans have competed on risk by averting high-risk populations. Competition based on prestige, however, is inherently costly and inflationary.

In the future, health care will be less about prestige and risk and more about price and quality, as in normal economic markets. In other words, it will be about value. Getting there, however, will be no easy task. Broadly speaking, it will require two corresponding sets of reforms: (1) pricing or payment reforms and (2) quality and outcome metrics. Combined, these two reforms speak to the notion of *value*: outcomes relative to costs. The ACA makes Medicare the principal laboratory for this two-track transformation of health care delivery and financing. Medicare's sheer size also shapes the practice and reporting behaviors of other actors in health care.

The ACA's proponents rightfully noted that the quality track requires a quality infrastructure—a set of measures, report-

ing rules, and mechanisms by which various metrics can be proposed, tested, and vetted (Miller & Arons, 2013; Sennett, 2010). The IMPACT Act expands mainly on this quality metric track and only secondarily on the payment reform track as it applies to postacute care. The act picks up where the ACA leaves off and gives the Centers for Medicare and Medicaid Services (CMS) more specific guidance on how to proceed. Ironically, in the extent to which it duplicates and expands on the ACA, the bipartisan IMPACT Act is a back-handed endorsement of one of the ACA's more important provisions by some of the ACA's most ardent critics.

## Main Provisions of the IMPACT Act

The IMPACT Act requires providers in all four postacute settings to collect and report three types of data: (1) patient assessment data, (2) quality measures, and (3) resource use measures.

### Patient Assessment Data

A vexing issue in postacute care is that each setting uses its own patient assessment instrument and an array of quality metrics derived from them. Moreover, these assessment tools are administered at different time intervals, making it difficult to make cross-setting comparisons with respect to severity of patient conditions and ultimate outcomes. The IMPACT Act calls for a more uniform system of measurement and reporting. In short, it aims to

make the setting-specific instruments more interoperable.

Attempts to address these differences predate both the ACA and the IMPACT Act. In 2000, CMS attempted to address them by making the Minimum Data Set (MDS), the instrument used in SNFs, the standard for patient assessment and resource use measurement across all four postacute settings. It would then become the basis for both quality measurement and for payment via the Resource Utilization Groups payment system that Medicare uses to pay SNFs. Naturally, providers in other settings balked, believing that the one-size-fits-all instrument was too cumbersome and too heavily weighted toward long-term care issues that nursing homes also have to address. Providers in other postacute settings persuaded Congress to allow them to retain their own patient assessment instruments and to develop setting-specific prospective payment systems more aligned with what they saw as their particular niche in postacute care.

In 2006, CMS launched another attempt to develop a uniform patient assessment instrument, this time using new statutory authority provided in the Deficit Reduction Act of 2005 (Pub. L. 109–171). This multiyear effort culminated in the development of the Continuity Assessment Record and Evaluation Tool, or CARE Tool. The final product, however, still had the lengthy look and feel of the MDS and its sister patient assessment instrument in home health care, the Outcome and Assessment Information Set (OASIS). The CARE Tool has not been implemented in its entirety, in part because of provider push-back from IRFs, LTCHs, and acute care hospitals that were also expected to complete the instrument on discharge.

CMS has since used the CARE Tool as an item library—the CARE Item Set—that allows practitioners in different settings to use various subsets of items in the CARE Tool that have the same measurement properties (CMS, 2015b). The IMPACT Act essentially ratifies this approach to allow for differences among settings. In short, SNFs will continue to use the MDS, HHAs will continue to use the OASIS, and IRFs will continue to use the IRF–Patient Assessment Instrument,

but they will also use assessment items from the same common menu. LTCHs, which did not have a patient assessment instrument until 2012, use a LTCH version of the CARE Tool, again with standardized data elements. Under the IMPACT Act, all postacute care providers must report data from the following CARE Item Set domains: (1) diagnoses, including comorbidities; (2) impairments; (3) functional status; (4) cognitive function and mental status; and (5) services and treatments required. In each instance, providers must use the same items from the CARE Item Set.

### *Quality Measures*

The IMPACT Act requires all four postacute settings to report five sets of quality data: (1) physical and cognitive function and changes in function; (2) skin integrity (i.e., onset and worsening of pressure ulcers); (3) medication reconciliation; (4) incidence of major falls; and (5) discharge planning, particularly the timely transfer of health information, including information on patient preferences, to the next care setting when a patient is discharged from an acute care setting or transferred from one postacute setting to another, including the home. The act also allows CMS to require postacute providers to report additional quality-related data items that it deems important.

### *Resource Use Measures*

The IMPACT Act requires postacute providers to report patient resource use using three main measures: (1) total Medicare spending per beneficiary, (2) whether the patient was discharged to the community, and (3) all-cause risk-adjusted preventable hospital readmission rates. This statutory requirement does not limit CMS from promulgating additional resource use measures. Note, however, that in the IMPACT Act “discharge to community” and “readmission rate” are considered resource use measures, although they are usually considered outcome or quality measures. These measures certainly have economic implications in the sense that they are associated with resource use, but they are not resource use measures.

Another odd reporting requirement is the amount of Medicare spending per beneficiary (MSPB). How MSPB will be operationalized and reported in postacute care remains unclear. However, if this measure follows the pattern seen in acute hospital care, it will mean the amount of Medicare Part A and Part B spending during (1) the postacute stay and (2) the first 30 days after the postacute stay (Medicare Payment Advisory Committee [MedPAC], 2015a). As such, MSPB is a resource measure. However, the IMPACT Act’s requirement that providers report such data seems odd because this information is already available to CMS through existing payment and claims data. (See also the discussion in the “Pending Follow-Up Legislation: HR 3298” section.) Fortunately, the IMPACT Act does allow CMS to add or remove reporting requirements, provided that CMS publishes its reasons for doing so in the *Federal Register* with opportunities for public comment before final changes are made.

### *Reporting Timelines*

The IMPACT Act includes an unusually detailed schedule of reporting requirements for both postacute providers and CMS, as outlined in Table 1. The timelines include 96 reporting dates stretching into 2021–2024 for each of the four postacute settings. Three things stand out. First, each care setting has a 1-yr interval between each reporting milestone for each quality or resource measure. Second, HHAs have milestones that fall on January 1; the other settings have milestones that fall on October 1, the beginning of the federal fiscal year. Third, SNFs and IRFs have the same timeline, presumably because policymakers have often considered these two settings as substitutes for each other, and concurrent data will provide a basis for determining whether Congress should require some type of “site-neutral” payment system for these two care settings.

Taking a step back, one sees not just 96 deadlines but also three phases of implementation: (1) data collection, reporting, and analysis; (2) feedback to providers; and (3) public reporting. Each phase commences 1 yr after the start of the previous

phase. More important, perhaps, such a detailed schedule of deadlines betrays a congressional distrust of CMS and its ability to meet self-imposed deadlines. This level of congressional micromanagement is unusual. Detailed scheduling is usually left to administrative rule making.

CMS has moved aggressively to meet these deadlines so that postacute providers can begin to collect and report these data starting October 1, 2016. The first task, however, is to define and operationalize each measure—not an incidental task. To do so, CMS convened technical expert panels (TEPs) for each quality and resource measure in 2015. The American Occupational Therapy Association has nominated several occupational therapy researchers who are serving, or have served, on these TEPs.

### *Risk Adjustment*

Providers are always concerned that comparisons of their performance with that of other providers will overlook differences in patient mix based on differences in age, illness severity, presence of comorbidities, and the like. Some facilities specialize in meeting the needs of more difficult patients and should not be penalized for such work. The IMPACT Act provides for risk adjustment to ensure that these variables are accounted for. However, the act leaves it to CMS’s discretion as to how to proceed. That said, the act also instructs the U.S. Department of Health and Human Services (CMS’s parent agency) to conduct studies on socioeconomic risk factors such as race, health literacy, and English proficiency and their association with quality measures and resource utilization. Health care providers have long argued that age, severity of patient condition, presence of comorbidities, and other clinical indicators are not adequate risk adjusters. They have argued that to make the system more risk neutral with respect to quality and payment, socioeconomic factors also need to be considered.

### *Larger Quality Metric Selection Ecosystem*

The IMPACT Act recognizes that the selection of quality measures takes place in

**Table 1. CMS Reporting Timelines**

Measure and Item	SNFs and IRFs			LTCHs			HHAs		
	Provider Reports	Feedback Reports <sup>a</sup>	Public Reports	Provider Reports	Feedback Reports	Public Reports	Provider Reports	Feedback Reports	Public Reports
<b>Quality</b>									
Functional status	10/1/16	10/1/17	10/1/18	10/1/18	10/1/19	10/1/20	1/1/19	1/1/20	1/1/21
Skin integrity, i.e., onset or worsening of pressure ulcers	10/1/16	10/1/17	10/1/18	10/1/16	10/1/17	10/1/18	1/1/17	1/1/18	1/1/19
Medication reconciliation	10/1/18	10/1/19	10/1/20	10/1/18	10/1/19	10/1/20	1/1/17	1/1/18	1/1/19
Major falls	10/1/16	10/1/17	10/1/18	10/1/16	10/1/17	10/1/18	1/1/19	1/1/20	1/1/21
Transfer of patient information to next setting of care	10/1/18	10/1/19	10/1/20	10/1/18	10/1/19	10/1/20	1/1/19	1/1/20	1/1/21
<b>Resource use</b>									
Medicare spending per beneficiary	10/1/16	10/1/17	10/1/18	10/1/16	10/1/17	10/1/18	1/1/17	1/1/18	1/1/19
Discharge to community	10/1/16	10/1/17	10/1/18	10/1/16	10/1/17	10/1/18	1/1/17	1/1/18	1/1/19
All-cause readmission rate	10/1/16	10/1/17	10/1/18	10/1/16	10/1/17	10/1/18	1/1/17	1/1/18	1/1/19

*Note.* Source of the data is from the Improving Medicare Post-Acute Transformation Act of 2014 (Pub. L. 113–185). CMS = Centers for Medicare and Medicaid Services; HHAs = home health agencies; IRFs = inpatient rehabilitation facilities; LTCHs = long-term care hospitals; SNFs = skilled nursing facilities.

<sup>a</sup>CMS will provide feedback reports to postacute providers based on their performance on each quality and resource use measure.

a larger ecosystem of consensus-building organizations and processes involved in the design and vetting of quality measures that include university research centers, TEPs, the Joint Commission, the National Committee on Quality Assurance, and many others. Chief among these organizations is the National Quality Forum, which sponsors stakeholder workgroups known as Measure Applications Partnerships (MAPs) in collaboration with CMS, including a MAP for the selection of postacute and long-term care measures (MAP, National Quality Forum, 2015). As does the ACA, the IMPACT Act requires that CMS seek the National Quality Forum’s endorsement when selecting quality measures specified in the act.

*Ancillary Provisions With Respect to Payment Reform*

Although the IMPACT Act focuses on the selection and application of quality and resource use measures, its intent is to lay the groundwork for payment reform. Hence, it calls on CMS to work with MedPAC—the nonpartisan congressional advisory body on Medicare payment policy—to develop a prototype prospective cross-setting, site-neutral payment system and to evaluate its probable effect on post-acute placement, utilization, overall post-acute spending, beneficiary cost sharing, access to care, and the like. After 2 yr of quality data collection, a report on this

prototype payment system would be due October 1, 2021. By June 30, 2022, MedPAC is to issue a second report that will operationalize the proposed payment system. These requirements dovetail well with MedPAC’s longstanding agenda to have a more patient-centric, site-neutral payment system, especially with regard to leveling SNF and IRF payment (MedPAC, 2015b).

*Costs Associated With Implementation*

The IMPACT Act sets aside \$130 million from the Medicare Trust Fund to implement the act’s various provisions over several years. A significant portion of these funds would presumably pay for various analyses to be conducted by MedPAC and CMS vendors.

**Pending Follow-Up Legislation: H.R. 3298**

Lurking in the current session of Congress is follow-up legislation, H.R. 3298, the Medicare Post-Acute Care Value-Based Purchasing Act of 2015. The bill has been touted by House Ways and Means Committee staff as the next iteration of the IMPACT Act (Committee on Ways and Means, 2015a, 2015b). The bill interestingly focuses on only one quality measure, namely, the MSPB, mentioned earlier. In the IMPACT Act, the MSPB is considered a resource measure. In H.R.

3298, it morphs into a quality measure and is meant to be the only quality measure for postacute care. The proposed bill would apply to payments starting in October 1, 2019, which syncs with the reporting requirements under the IMPACT Act outlined in Table 1.

**Was the IMPACT Act Really Needed?**

When it passed, the IMPACT Act was acclaimed by its champions as one of the few examples of congressional bipartisanship (Committee on Ways and Means, 2014). This brief moment of self-congratulatory bipartisan policy development was not warranted because the act mainly ratified changes that were already under way in Medicare and, in the broad scheme of things, broke little new ground apart from its specific timelines. Nonetheless, it will remain with us for the next several years, and thus postacute stakeholders need to come to terms with it. Much less innocuous, if not potentially harmful, is the IMPACT Act’s proposed sequel, H.R. 3298, which is mislabeled as a postacute value-based purchasing (VBP) program.

In some ways, the IMPACT Act replicates the authority already provided to CMS by the ACA 4 yr earlier to develop, vet, and implement quality measures for postacute care, and, in some respects, the ACA, and CMS’s

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implementation thereof, is ahead of the development curve outlined in the IMPACT Act. For example, the ACA's § 3004 provides for a quality reporting program for IRFs and LTCHs that includes many of the same kinds of development, endorsement, and public reporting steps outlined in the IMPACT Act, with similar 2% payment penalties for failing to report in a timely manner.

The ACA is also ahead of the curve with respect to VBP than is the IMPACT Act's proposed follow-up bill, H.R. 3298. The ACA's § 3006 requires CMS to develop a VBP plan for SNFs and HHAs in 2011 (CMS, 2011) and is already implementing an HHA VBP plan for fiscal year 2016 (CMS, 2015e) and an SNF VBP plan for fiscal year 2019 as authorized by the Protecting Access to Medicare Act of 2014 (Pub. L. 113–93; CMS, 2015d). The ACA's § 10326 requires CMS to pilot test a pay-for-performance program for IRFs, although its outcome remains unclear.

On the payment reform track, the IMPACT Act, like MedPAC, appears fixated on the development of a prospective site-neutral payment system that would replace the four separate prospective payment systems now used in postacute care. Using its authority under the ACA, CMS is already pushing postacute care into a more advanced site-neutral payment system, namely, bundled payment for entire episodes of care. Before passage of the IMPACT Act, CMS had already launched its Bundled Payment for Care Improvement program in 2013 (CMS, 2015a), and in 2016 it is implementing its Comprehensive Care Joint Replacement bundled payment program in 67 markets around the country (CMS, 2015c). Under the IMPACT Act, MedPAC's prototype prospective site-neutral payment plan is not due until 2022.

In short, was the IMPACT Act needed given the authority that CMS already had under the ACA, including its innovation authority? The act indeed backfills portions of the ACA with respect to postacute care but also stretches the timeline of postacute care reform toward value- and episode-based bundled payment well into the next decade.

## Implications for Occupational Therapy Advocacy and Practice

Regardless of their relative importance, the IMPACT Act and the ACA that preceded it, both point in the same direction: toward value-based care, episode-based management, and bundled payment. The ACA goes further than the IMPACT Act, namely, moving toward care management and payment that is episode based and even population based, as in the case of accountable care organizations (ACOs). Movement along this arc of change remains relentless. The ACA endorsed and accelerated this transition; the IMPACT Act shifts the timing of this transition with respect to postacute care.

### *Marking Territory and Defining Value*

Health policy changes and major transitions, such as the one now under way, can provoke anxiety among health care stakeholders, including individual health professions such as occupational therapy. Health professions naturally seek to guard, if not advance, their role and prerogatives in the health care system to protect their practice domains, prestige, legitimacy, and sources of payment. In the current but fading fee-for-service payment system, a profession typically does so through credentialing, state practice laws, and the like but also by guarding specific bits and pieces of documentation needed for reimbursement and quality assessment.

For occupational therapy, this process may include making sure that occupational therapy is included in health benefits packages, that the *Current Procedural Terminology*<sup>®</sup> (American Medical Association, 2015) includes acceptable occupational therapy–related codes, that functional assessment instruments include domains (e.g., upper-limb mobility, functional cognition) that reflect occupational therapy's involvement or contributions, and that electronic medical records (EMRs) include codes and descriptors for occupational therapy inputs. These are some of the ways in which health professions mark territory and validate their role in the health system. This territorial marking behavior is entirely predictable, but it is also necessary in a fee-for-service system.

Over time, territorial marking as practitioners have known it will become

obsolete, but marking a place in the system will remain necessary. In future years, a health profession's legitimacy will depend less on what it does and the procedural codes it checks off and more on how it adds value to overall patient outcomes. Coding, documentation, and scope of practice may still be relevant but in different ways. Both in practice and in advocacy, the relevant question is not whether occupational therapy is adequately represented but how occupational therapy—its timing, type of intervention, and intensity—adds value for the patient and the health care system broadly in both the near and the long term. If value is measured by health outcomes divided by costs, then it is essential that the profession advocates for outcomes that are in accord with patient goals and societal values that also reflect occupational therapy impacts. To do so requires scientific evidence resulting from a robust research agenda and credible evidence stemming from patient cohort studies using nimble electronic data systems.

### *Holding Bundlers and Upstream Providers Accountable for Distal Outcomes*

In a MSPB or bundled payment world, in which downstream postacute providers such as occupational therapy practitioners believe they may be short changed by bundlers and upstream providers who do not value postacute care, it is essential that upstream providers be made accountable for longer term outcomes to which occupational therapy practitioners can contribute. Absent such outcomes and accountability, upstream providers will not be motivated to contract with high-quality downstream providers, including occupational therapy practitioners. Hence, rather than fighting over the distribution of acute and postacute care dollars, the profession would be better served by focusing on longer term outcomes, making them part of the bundled payment or VBP regimen, and “baking” them into health system gainsharing formulas that will motivate upstream providers to work collaboratively with downstream health professions.

In short, health professions such as occupational therapy need to make sure that episode- and population-based payment will, in part, be tied to more distal outcomes to which they can contribute.

The occupational therapy profession also needs to demonstrate how it contributes to outcomes, both near and long term, in upstream settings such as primary and acute care—especially in the case of population health strategies such as ACOs.

The temptation is to advocate for process quality measures rather than for more distal outcome measures for payment and public reporting purposes—*temptation* because it is easier to associate a given profession's tool kit or intervention repertoire with process measures than with outcome measures. Yet, value is about outcomes, not processes. Process quality measures are internal care management checkpoints that can, and should, change when better processes are uncovered through research and through trial and error in the search for best practice—practice that will advance outcomes most valued by patients, their families, payers, and society at large.

## Conclusion: Becoming Smart Clinicians

In short, episode- and value-based payment will change the rules of the game for all stakeholders. In the future, therapists need to measure their productivity not in terms of therapy hours per day or some other unit of input but in terms of how they will add value for all stakeholders, especially patients. This change will require that therapists become “smart” clinicians. By *smart*, I mean becoming sophisticated users of the “big data” analytics needed to customize and improve care in ways that will enhance the patient experience and patient outcomes. Only by becoming smart will individual health professions be able to articulate how they provide real value for a given patient or group of patients.

Being smart also means not being locked into inflexible protocols or “dumb” regulations (e.g., fixed hours of therapy per day in an 8:00–5:00 setting) but rather asking at every turn how occupational therapy practitioners can add value. In the value-based health care world envisioned in the ACA and the IMPACT Act, we have to become smarter than we ever have been before. Fortunately, emerging technologies—from EMRs to smartphones and advances in data visualization—will enable and empower health profes-

sionals and patients alike to tailor and advance practice in ways heretofore unseen. These technologies also require, however, the willingness to shed old ways of thinking, learn new technologies, and embrace new ways of delivering and managing care. ▲

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