Compliance Auditing and Monitoring in a Value Based World
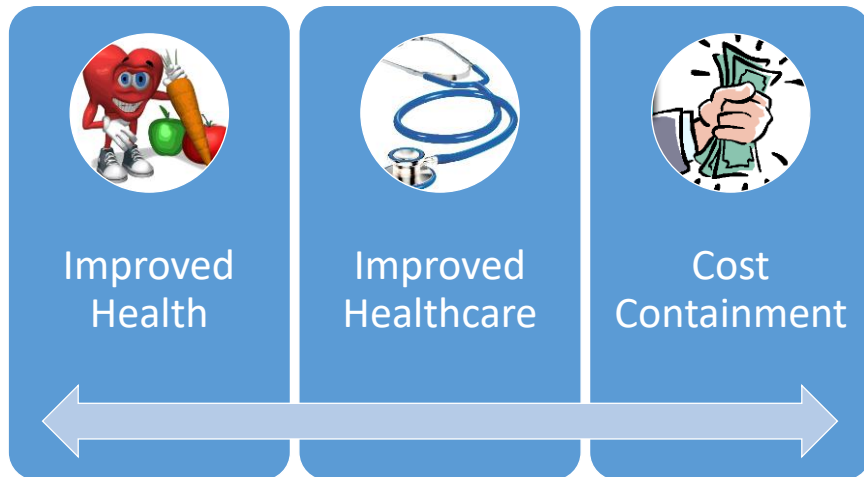
David Fuchs
Senior Counsel, Office of Counsel to the IG, U.S. Department of Health and Human Services

Shawn Halcsik DPT, MEd, RAC-CT, CPC, CHC
Corporate Compliance Officer, Encore Rehabilitation
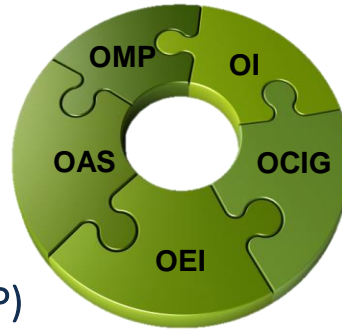
Health Care Reform

| Improved Health | Improved Healthcare | Cost Containment |

OIG's Use of Data

How OIG Uses Data to
Inform and Fulfill Its Mission

OIG Organization

- Office of Audit Services (OAS)
- Office of Evaluation and Inspections (OEI)
- Office of Investigations (OI)
- Office of Counsel to the Inspector General (OCIG)
- Office of Management & Policy (OMP)

OMP
OI
OAS
OCIG
OEI

5

Office of the Chief Data Officer

Vision: Empowering OIG to use data proactively and become the model for using data to fight fraud, waste, and abuse and improve program efficiency, effectiveness and economy

Data Analytics
Steve Shandy

Vision: DDA will deliver a full range of analytics, from simple to sophisticated, and leadership to the organization by identifying new areas of focus to help OIG protect people and HHS programs.

Major Initiatives: Analytic support for OIG Priority Outcomes, OIG Analytics Hub, Grant Analytics Portal, statistical modeling for proactive oversight, and customized data and analytic support for OIG.

Data Operations
Kirsten Dalboe

Vision: Data Operations' passion and investment will drive organization -wide data maturity to enable trusted analysis.

Major Initiatives: Modernization of OIG's Integrated Data Platform, Information Governance, Mission and Operational Data Working Groups, Data Catalog, data guidance and best practices.

Planning, Measurement, and Delivery
Michael O'Rourke

Vision: PMD will enable clear and confident strategic decision making.

Major Initiatives: The Enterprise Dashboard, OIG Work Plan, OIG Updates, Innovation and Performance Brown Bags, OIG Priority Outcomes and the Incubator.

Division of Data Analytics Vision and Purpose

Vision

DDA will deliver a full range of analytics, from simple to sophisticated, and leadership to the organization by enabling OIG to identify new areas of focus to help OIG protect people and HHS programs.

Core Purposes

- Provide OIG with the analytics needed to equip, empower, and support the agency mission of fighting fraud, waste, and abuse in HHS programs.
- Drive development of a range of analytics so customers get results timely and DDA innovation expands OIG analytics to new and higher levels.
- Enable self-service analytics and data sharing options, allowing the DDA to focus on more complex efforts.

How we use data & analytics

Detect fraud
Reduce improper payments
Identify emerging trends
Support investigations
Identify high risks
Identify audit risk areas
Support evaluations
Identify potential targets
Help prioritize and triage
Detect anomalies or outliers
Identify vulnerabilities
All of the above

OIG Analysis Approaches

- Total Payments and Trends
- Per Capita Payments
  - total eligible beneficiaries (PAYGAR)
  - Beneficiary utilization (avg. payment/bene trends)
- Disproportionate Payments (PAYGAR)
- Questionable Billings (See published OEI reports for Part D pharmacies, HHAs, etc.)
- High-Risk Providers (Not published)
- Customized for Ad Hoc requests for OIG oversight – audits, evaluations, investigations and ACL, provider compliance, etc.
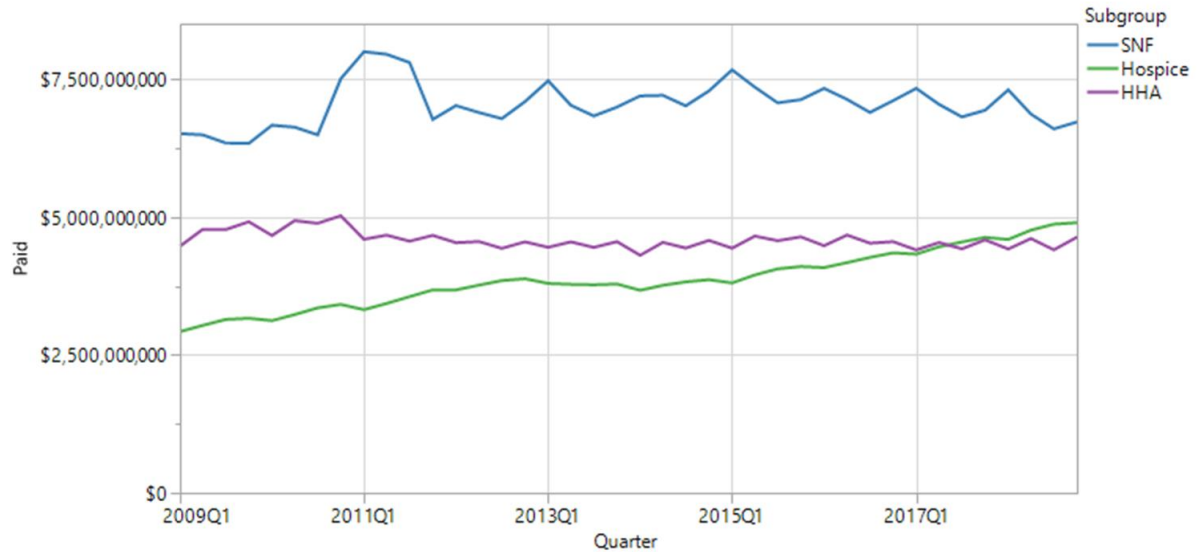
9

National Medicare Trends

National Quarterly Trend in Paid Amount by Claim Type
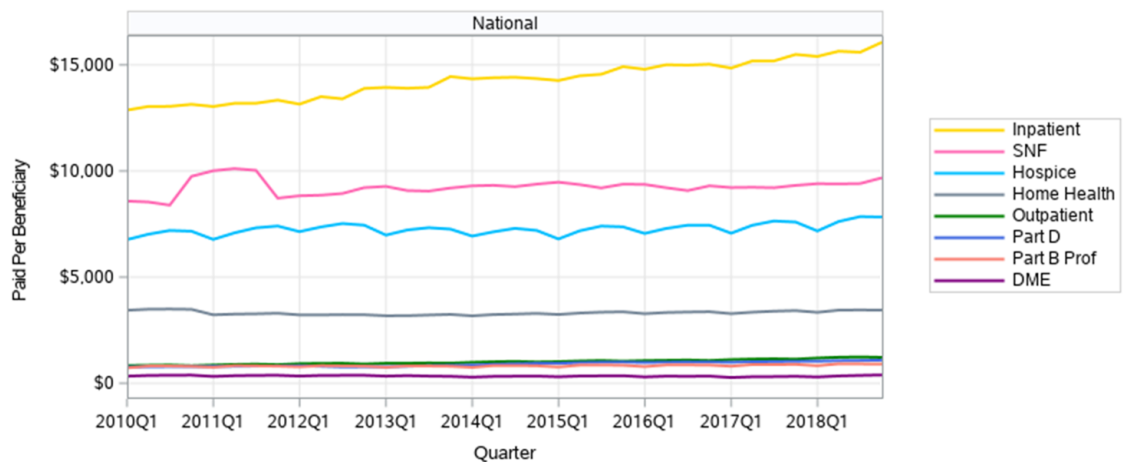January 1, 2010 to December 31, 2018
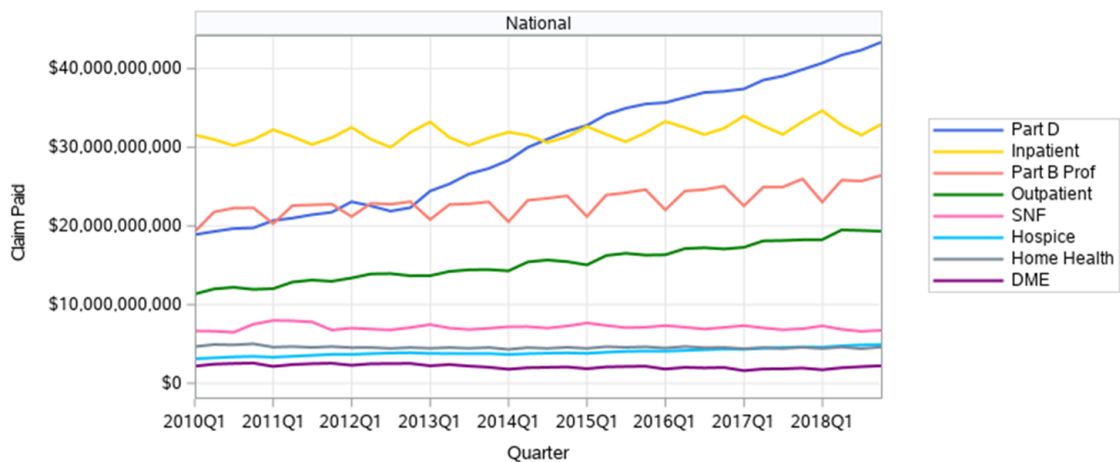
National Medicare Trends (zoom for Part A)

National Medicare Payment Trends per patient

Medicare Payment For Rehab Therapy in SNFs

Rehab in SNFs Nationally: Quarterly Trend in Total Paid
January 1, 2010 to December 31, 2018

Medicare Payment For Rehab Therapy in SNFs

Rehab in SNFs: Quarterly Trend in Paid Per Beneficiary
January 1, 2010 to December 31, 2018

Medicare Payment For Rehab Therapy in SNFs

Rehab Intensity Breakdown in SNFs Nationally: Quarterly Trend in Total Paid
January 1, 2010 to December 31, 2018

Medicare Payment For Rehab Therapy in SNFs
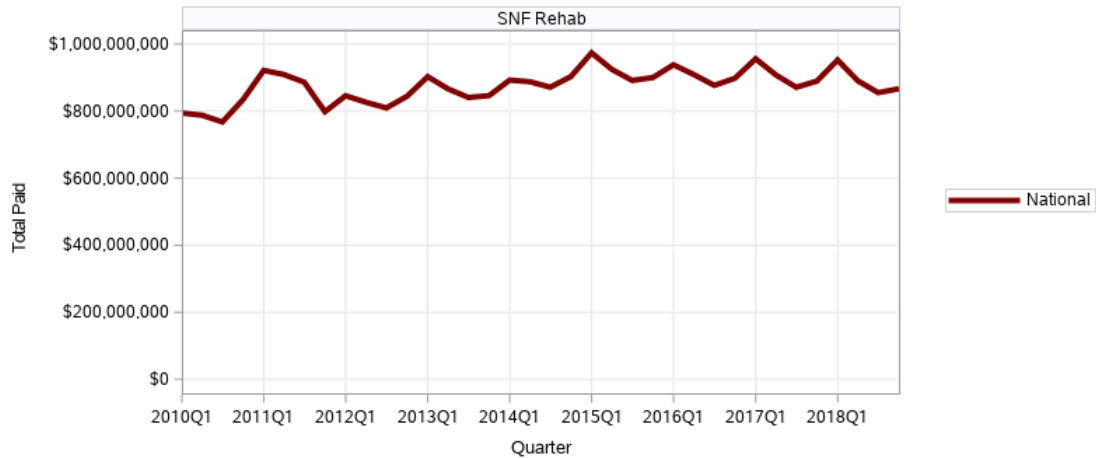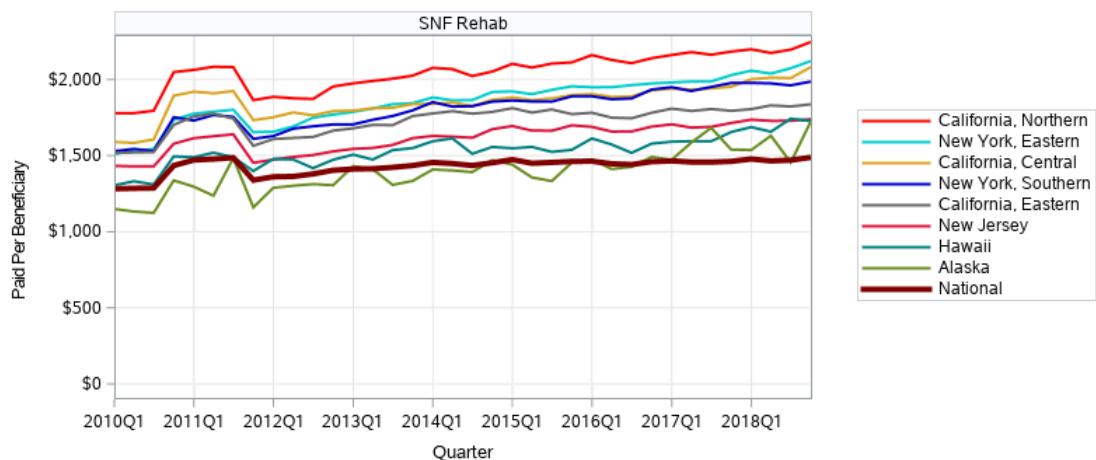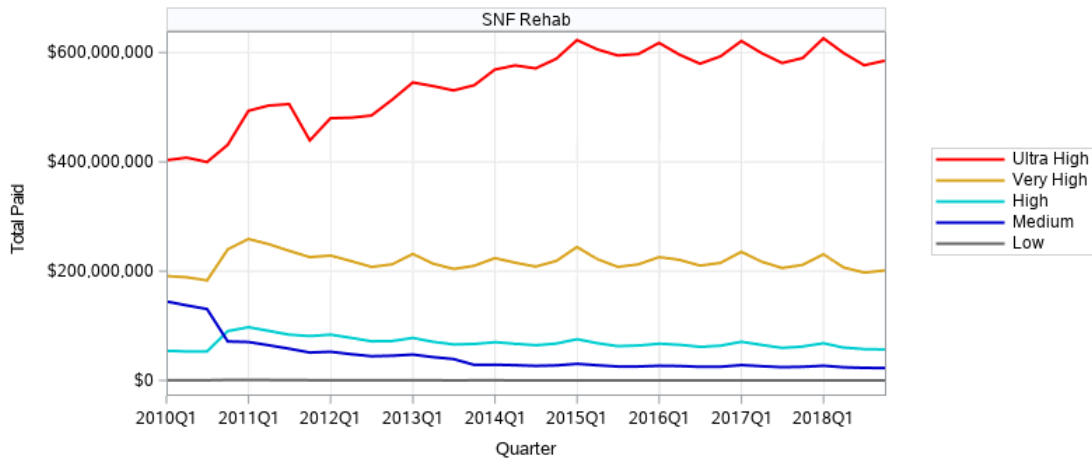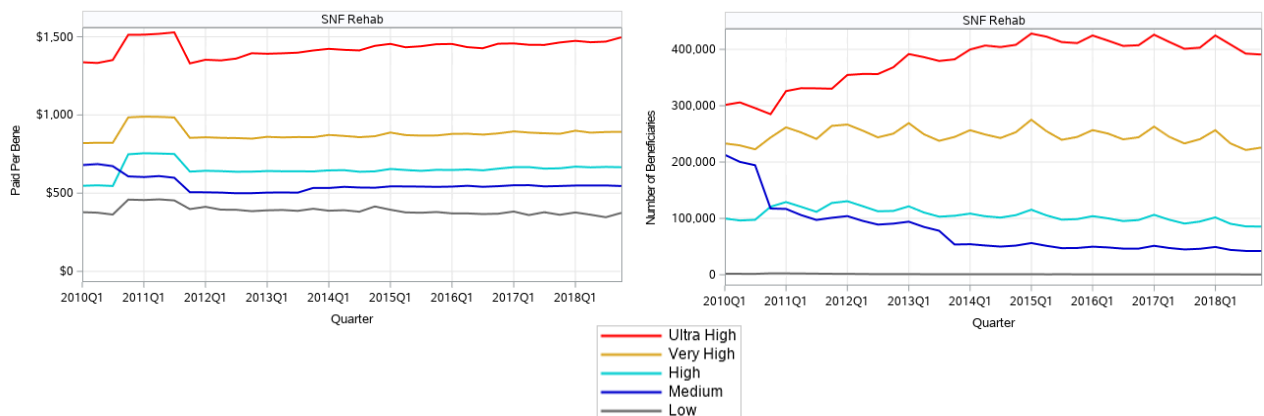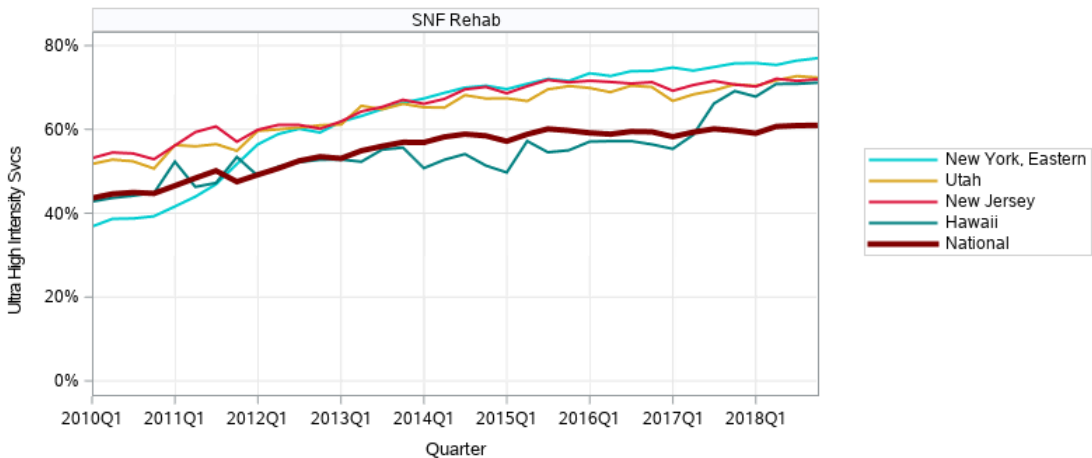
Rehab Intensity Breakdown by SNFs Nationally: Quarterly Trends in Paid Per Bene and Number of Benes
January 1, 2010 to December 31, 2018

Medicare Payment For Rehab Therapy in SNFs

Ultra High Intensity Rehab at SNFs: Quarterly Trend in Ultra High Intensity Svcs
January 1, 2010 to December 31, 2018

SNF Rehab

(Chart: Ultra High Intensity Svcs, y-axis 0% to 80%, x-axis 2010Q1 to 2018Q1, Quarter. Lines for:)
- New York, Eastern
- Utah
- New Jersey
- Hawaii
- National

Disproportionate Payments

- Analytic methodology OIG developed to help inform HHS and DOJ management decisions for Medicare Fraud Strike Force expansion
- Current Metrics
  - Total Payments
  - Per Capita Payments ($ per Enrolled/Eligible Benes. _Note: This method differs from $ per patient who received the service displayed in previous trends charts._)
  - Disproportionate Payments Exceeding 2X U.S. national average.
  - Disproportionate Payments Exceeding 3X U.S. national average.
- Forthcoming
  - Per Patient Payments ($ per beneficiary who rec'd the service);
  - Already in use in OIG Predictive Analytics

Disproportionate Payments

PAYGAR Service Categories for Medicare FFS: 3 Levels

1. Medicare Part	2. General category	3. Specific category
Part A	Claim type (HHA, SNF, Inpatient, Hospice)	n/a
Part B of A (Outpatient)	Type of bill (ASC, CMHC, Outpatient Hospital, etc.)	n/a
Part B	General BETOS category (Evaluation & Management, Procedures, etc.)	Specific BETOS code (Office Visits – New, Anesthesia, etc.)
Part D	Enhanced Therapeutic Class Level 1 (Antineoplastics, Dematological, etc.)	Enhanced Therapeutic Class Level 2 (Antineoplastics – Immunomodulators, Dermatological – Antipsoriatics, etc.)

Disproportionate Payments: PAYGAR

Disproportionate Payments: PAYGAR

Disproportionate Payments: PAYGAR

OIG Customized Analysis for OI case

SNF Therapy Services – Peer Comparison Analysis
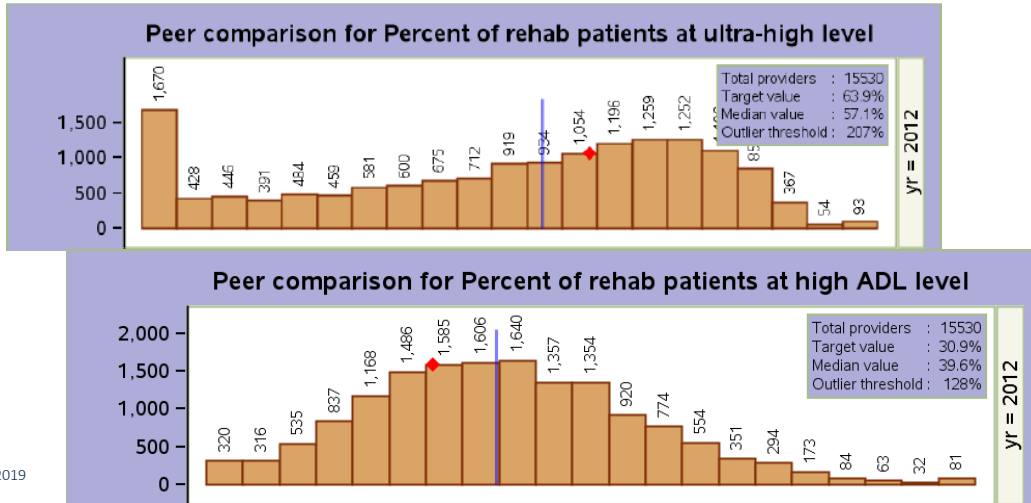
OIG Customized Analysis for OI case
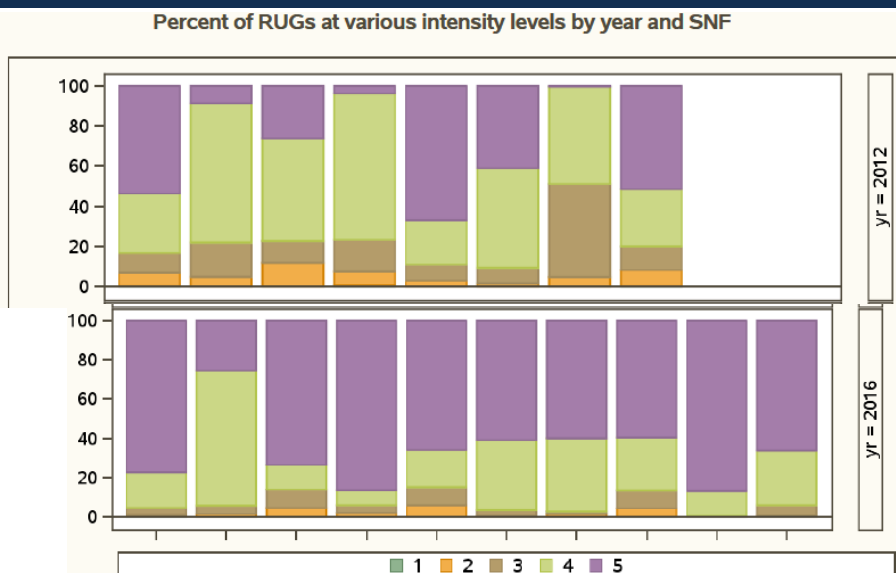
OIG Customized Analysis for OI case

SNF –

Average (Mean)
Length of Stays

Mean days per bene per SNF

state_days_per_bene

13.3077 - 41.7776	50.5391 - 55.5454
42.8766 - 48.6221	60.7331 - 69.1045
55.8054 - 60.2831	69.3630 - 137.3567

Produced by CDAC on 21FEB2017
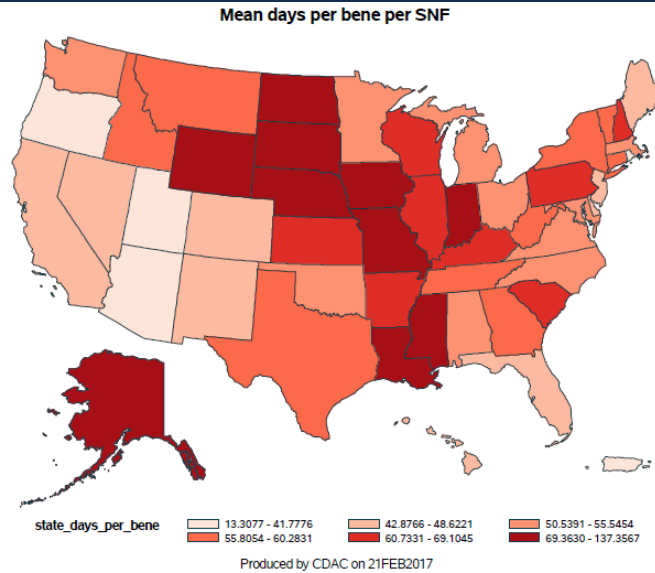
OIG Customized Analysis for OI case

OIG SNF case:
Comparison
of Average
Length of Stay

OIG subject
SNF chain vs.

All Other SNFs
by State

Mean days per beneficiary by State and SNF chain
Vertical bars represent mean days per bene

☐ Other ☐ Subject of OIG investigation

	AL	CA	GA	KS
	101.87 / 60.68	168.58 / 62.31	70.67 / 68.43	188.95 / 77.62
	9.02%	0.24%	9.15%	5.34%

	KY	MA	MD	MN
	140.89 / 76.43	117.41 / 66.26	123.79 / 64.62	85.88 / 60.54
	5.11%	5.51%	0.55%	8.91%
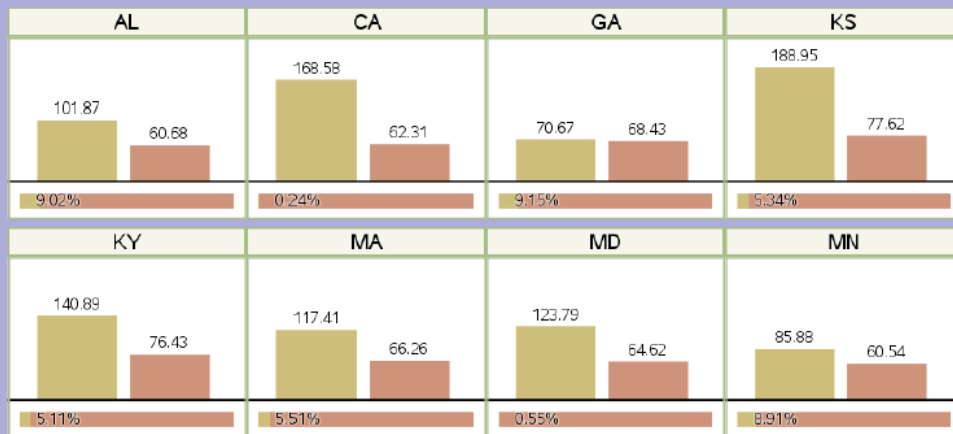
Health Care Paradigm Shift

Reforming
- Patient centric
- Incentives for outcomes
- Coordinated care
- **Value based**/ alternative payment

Historical
- Provider centric
- **Incentives for volume**
- Siloed care
- Fee for service
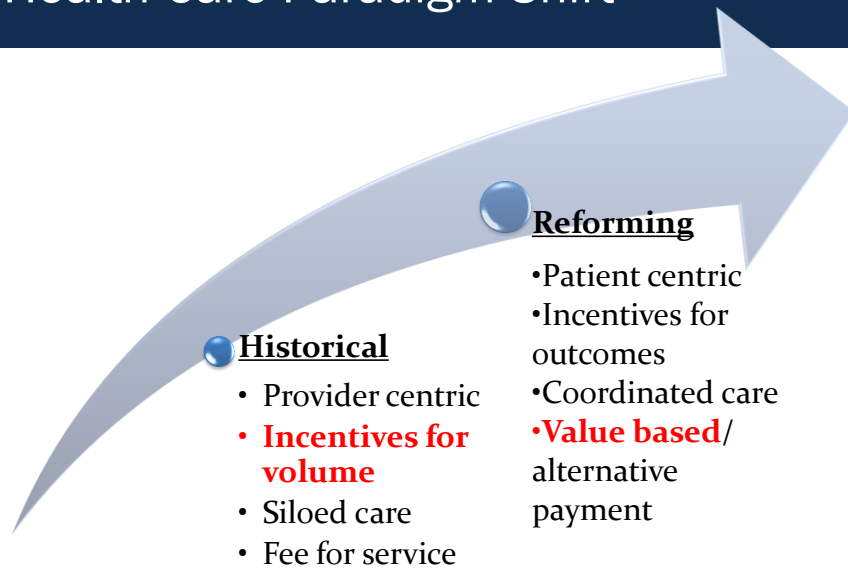
IMPACT Act and Post Acute Care

- Bipartisan bill signed into law October 6, 2014
- The Act requires the submission of standardized data by
  - Inpatient Rehabilitation Facilities (or IRFs) on the Inpatient Rehabilitation Facility Patient Assessment Instrument (or IRF-PAI)
  - Skilled Nursing Facilities (or SNFs) on the Minimum Data Set (MDS)
  - Home Health Agencies (or HHAs) on the Outcome and Assessment Information Set (OASIS)
  - Long-Term Care Hospitals (or LTCHs) on the CARE date set
- The collection of standardized patient assessment data across PAC settings
  - enables quality care and improved outcomes
  - creates uniformity in data elements between settings
  - enhances the ability to compare data across PAC settings
  - improves the ability to exchange data
  - improves discharge planning and care coordination
  - informs payment models

Functional status, cognitive function, and changes in functional and cognitive function	Skin integrity and changes in skin integrity	Medication Reconciliation
• SNF: October 1, 2016 • IRF: October 1, 2016 • LTCH: October 1, 2018 • HHA: January 1, 2019	• SNF: October 1, 2016 • IRF: October 1, 2016 • LTCH: October 1, 2016 • HHA: January 1, 2017	• SNF: October 1, 2017 • IRF: October 1, 2018 • LTCH: October 1, 2018 • HHA: January 1, 2017

Incidence of major falls	Communicating the existence of and providing for the transfer of health information and care preferences	Resource use and other measures
• SNF: October 1, 2016 • IRF: October 1, 2016 • LTCH: October 1, 2016 • HHA: January 1, 2019	• SNF: October 1, 2018 • IRF: October 1, 2018 • LTCH: October 1, 2018 • HHA: January 1, 2019	• SNF: October 1, 2016 • IRF: October 1, 2016 • LTCH: October 1, 2016 • HHA: January 1, 2017

1	**PPS, PDPM, PDGM and a Unified Payment Model**
2	**Home Health & Skilled Nursing Facility Quality Measures**
3	**Monitoring and Auditing**

Why change the payment model?

- Primary goals:
  - De-incentivize volume
  - Focus on patient characteristics
  - Better capture high cost services for medically complex

Data Points under Volume Based Models

Home Health
- Therapy Visits
  - 5-6
  - 20+
- Outlier Payments
- Number of Episodes (Length of Stay)

Skilled Nursing Facility
- Minutes of therapy
  - Ultra High (720+)
- Nontherapy RUGs with High ADLs
- Length of Stay
- Community DC rate

HH: What does not change

- Home Bound
- No changes to the requirements for certification/recertification
- No changes to OASIS completion requirements
- No change to requirements for updating patient plan of care
- Must meet Rules of Participation
- Held accountable to QRP, VBP, and other QMs that impact ratings or are publically reported
- This is a PAYMENT model change
  - Personnel Qualifications remain
    - State Practice Act Implications
  - Verifiable Patient Characteristics

Home Health

Current
- HHAs complete Outcome and Assessment Information Set (OASIS) for each patient
- The OASIS groups the patient into one of 153 Home Health Resource Groups (HHRGs)
  - Timing of the episode
  - Clinical domain
  - Functional domain
  - Service Utilization (therapy visits)

PDGM (January 1, 2020)
- Bill every 30 days rather than 60 days
- 5 main case-mix variables result in 432 case-mix groups

Admission Source and Timing (From Claims)
Community Early | Community Late | Institutional Early | Institutional Late

Clinical Grouping (From Principal Diagnosis Reported on Claim)
Neuro Rehab | Wounds | Complex Nursing Interventions | MS Rehab | Behavioral Health | MMTA – Other
MMTA – Surgical Aftercare | MMTA – Cardiac and Circulatory | MMTA – Endocrine | MMTA – GI/GU¹ | MMTA – Infectious Disease² | MMTA – Respiratory

Functional Impairment Level (From OASIS Items)
Low | Medium | High

Comorbidity Adjustment (From Secondary Diagnoses Reported on Claims)
None | Low | High

HHRG
(Home Health Resource Group)

Under the Patient-Driven Groupings Model, a 30-day period is grouped into one (and only one) subcategory under each larger colored category. A 30-day period's combination of subcategories places the 30-day period into one of 432 different payment groups.

Institutional
▪Acute inpatient; Post-acute (SNF, IRF, long-term care hospital or inpatient psychiatric facility); 30 day periods with this admission source were noted to have higher resource use than periods with a community admission source

Community
▪No acute or post-acute care in the 14 days prior to the HH admission

M1810 – Current ability to dress upper body safely
M1820 – Current ability to dress lower body safely
M1830 – Bathing
M1840 – Toilet transferring
M1850 – Transferring
M1860 – Ambulation/locomotion
M1800 – Grooming
M1033 – Risk for hospitalization

Each 30 day period receives one of three adjustments:
▪No adjustment – no reported secondary diagnosis that falls into the low or high category
▪A low adjustment – the patient has one reported secondary diagnosis that is associated with higher resource use
▪A high adjustment – the patient has two or more reported secondary diagnoses that are associated with higher resource use when both are reported together compared to if they were reported separately

SNF: What does not change

- Coverage Guidelines for SNF remain
  - Care in a SNF is covered if all of the following four factors are met:
    - The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;
    - The patient requires these skilled services on a daily basis (see §30.6); and
    - As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7.)
    - The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.
- Certification and Re-Certification Requirements remain
- Must meet Rules of Participation
- Held accountable to QRP, VBP, and other QMs that impact ratings or are publically reported
- This is a PAYMENT model change
  - Personnel Qualifications remain
    - State Practice Act Implications
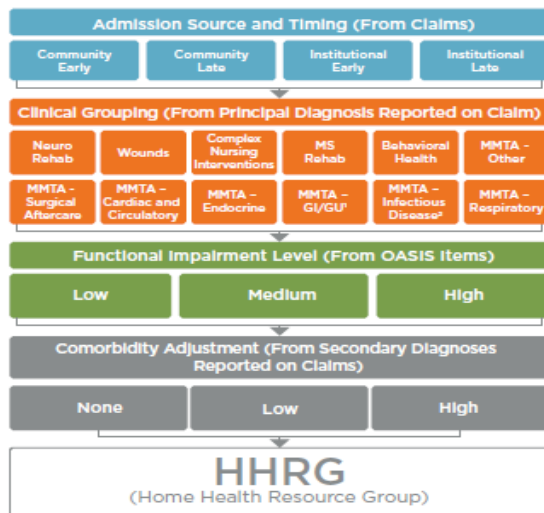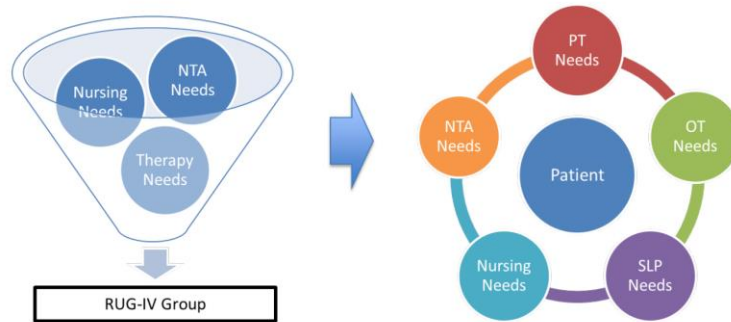 - Verifiable Patient Characteristics

RUG-IV vs. PDPM

- While RUG-IV (left) reduces everything about a patient to a single, typically volume-driven, case-mix group, PDPM (right) focuses on the unique, individualized needs, characteristics, and goals of each patient:

PT	• PT ---all patients will be assigned to a case mix level • 16 case mix levels based on clinical category (4) and functional level (Section GG items) • MDS Sections I, J, GG
OT	• OT– all patients will be assigned to a case mix level • 16 case mix levels based on clinical category (4) and functional level (Section GG items) • MDS Sections I, J, GG
SLP	• SLP—all patients will be assigned to a case mix level • 12 case mix levels based on Presence of acute neuro condition, SLP related co-morbidity, or cognitive impairment & mechanically altered diet or swallowing disorder • MDS Sections, I, J, K, C, B, O
Nursing	• Nursing—all patients will be assigned to a case mix level • 25 case mix levels based on clinical conditions, depression, # restorative services, function (section GG)
NTA	• NTA—all patients will be assigned to a case mix level • 6 case mix levels based on conditions • MDS Sections I, H, K, M, O
Non Case Mix	• Non Case Mix

Modes of Treatment

- Limits concurrent and group to no more than 25%, COMBINED, by discipline
- Will require completion of a discharge MDS to collect therapy minutes for compliance monitoring of 25% concurrent and group
- Utilization of group &/or concurrent must be based on needs of resident and must be well documented
- Non fatal warning edit on validation report if exceed threshold

Section O Additions

> Requiring reporting of minutes and days will allow for Compliance monitoring by CMS of daily intensity (pg 242)

TABLE 35: Proposed Items to Add to SNF PPS Discharge Assessment

MDS Item Number	Item Name
O0400A5	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Therapy Start Date
O0400A6	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Therapy End Date
O0400A7	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Individual Minutes
O0400A8	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Concurrent Minutes
O0400A9	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Group Minutes
O0400A10	Special Treatments, Procedures and Programs: Speech-Language Pathology and Audiology Services: Total Days
O0400B5	Special Treatments, Procedures and Programs: Occupational Therapy: Therapy Start Date
O0400B6	Special Treatments, Procedures and Programs: Occupational Therapy: Therapy End Date
O0400B7	Special Treatments, Procedures and Programs: Occupational Therapy: Total Individual Minutes
O0400B8	Special Treatments, Procedures and Programs: Occupational Therapy: Total Concurrent Minutes
O0400B9	Special Treatments, Procedures and Programs: Occupational Therapy: Total Group Minutes
O0400B10	Special Treatments, Procedures and Programs: Occupational Therapy: Total Days
O0400C5	Special Treatments, Procedures and Programs: Physical Therapy: Therapy Start Date
O0400C6	Special Treatments, Procedures and Programs: Physical Therapy: Therapy End Date
O0400C7	Special Treatments, Procedures and Programs: Physical Therapy: Total Individual Minutes
O0400C8	Special Treatments, Procedures and Programs: Physical Therapy: Total Concurrent Minutes
O0400C9	Special Treatments, Procedures and Programs: Physical Therapy: Total Group Minutes
O0400C10	Special Treatments, Procedures and Programs: Physical Therapy: Total Days

What Will CMS Monitor?

- Changes in payment that result from changes in the coding or classification of SNF patients vs. actual changes in case mix.
- Changes in the volume and intensity of therapy services provided to SNF residents under PDPM compared to RUG-IV.
- Compliance with the group and concurrent therapy limit.
- Any increases in the use of mechanically altered diet among the SNF population that may suggest that beneficiaries are being prescribed such a diet based on facility financial considerations, rather than for clinical need.
- Any potential consequences (e.g., overutilization) of using cognitive impairment as a payment classifier in the SLP component.
- Facilities whose beneficiaries experience inappropriate early discharge or provision of fewer services (e.g., due to the variable per-diem adjustment).
- Stroke and trauma patients, as well as those with chronic conditions, to identify any adverse trends from application of the variable per-diem adjustment.
- Use of the interrupted-stay policy to identify SNFs whose residents experience frequent readmission, particularly facilities where the readmissions occur just outside the 3-day window used as part of the interrupted-stay policy.

1	PPS, PDPM, PDGM and a Unified Payment Model
2	Home Health & Skilled Nursing Facility Quality Measures
3	Monitoring and Auditing

Short Stay

Measure	QM	QRP	VBP	Five Star	Nursing Home Compare
Self-Report Moderate to Severe Pain	✓			✓	✓
Pressure Ulcers that are New or Worsened	✓	✓		✓	✓
Newly Received an Antipsychotic Medication	✓			✓	✓
Made Improvements in Function	✓			✓	✓
Assessed and Given Appropriately the Seasonal Influenza Vaccine	✓				✓
Assessed and Given Appropriately the Pneumococcal Vaccine	✓				✓

QRP FY2020: Approved Measures with Data Collection Which Began Oct. 1, 2018

Measure	QM	QRP	VBP	Five Star	Nursing Home Compare
Drug Regimen Review		✓			
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury		✓			
Change in Self Care		✓			
Change in Mobility		✓			
Discharge Self Care		✓			
Discharge Mobility		✓			

MDS Section	PDPM	QMs-Short Stay	QRP-Short Stay	QMs-Long Stay	QRP-Long Stay	Survey Critical Pathways
A				✓	✓	✓
B	✓			✓		✓
C	✓					✓
D	✓			✓		✓
E	✓			✓		✓
F	✓					✓
G		✓		✓		✓
GG	✓ ⚡		10/1/18 ⚡	✓	✓	✓
H	✓			✓		✓
I	✓			✓		✓
J	✓	✓		✓	✓	✓
K	✓			✓		✓
L						✓
M	✓	✓	✓	✓		✓
N	✓	✓		✓		✓
O	✓	✓		✓		✓
P				✓		✓

1	**PPS, PDPM, PDGM and a Unified Payment Model**
2	**Home Health & Skilled Nursing Facility Quality Measures**
3	**Monitoring and Auditing**

Know Your Risk Areas

Home Health
- What are your primary diagnoses not on the approved list
- What are your risky utilization patterns
- What are your clinical challenges
- What are your problem referral sources

SNF
- What are your primary diagnoses not on the approved list
- What are your utilization patterns
  - Intensity
  - Mode
- What are your clinical challenges
- Is the documentation present for capture of Nursing and NTA

Know Your Data

Home Health
- PEPPER
- Quality Outcomes
- Readmission Rates
- Star Ratings
- Clinical Care Data from Claims

SNF
- PEPPER
- Quality Outcomes
- Readmission Rates
- Star ratings
- Clinical Care Data from Claims

Data Points under Volume Based Models

Home Health Today
- Therapy Visits
  - 5-6
  - 20+
- Outlier Payments
- Number of Episodes (Length of Stay)

Home Health PDGM
- Admission Source
- Length of Stay
- Primary Dx
- Comorbidities
- Accuracy of Function Reporting
- Quality Measures

Data Points under Volume Based Models

SNF PPS RUGS IV
- Minutes of therapy
  - Ultra High (720+)
- Length of Stay
- Community DC rate
- Rehospitalization Rate
- Functional Change

SNF PPS PDPM
- Length of Stay
- Community DC Rate
- Rehospitalization Rate
- Functional Change (GG) QM/QRP
- MDS Accuracy:
  - Section K, B, C, I, J, GG, H, M, O
- Mode of treatment %

PDPM Audit Focus Areas

- Accurate Coding of MDS -- Develop schedule by section that will impact PDPM and QM
  - Section K Any increases in the use of mechanically altered diet among the SNF population that may suggest that beneficiaries are being prescribed such a diet based on facility financial considerations, rather than for clinical need.
  - Sections B/C Any potential consequences (e.g., overutilization) of using cognitive impairment as a payment classifier in the SLP component.
  - Section GG
  - Nursing and NTA
- Accurate diagnosis coding
- Section O Therapy Delivery Changes in the volume and intensity of therapy services provided to SNF residents under PDPM compared to RUG-IV.
  - Average care every 7 days
- CONCURRENT & GROUP
  - Appropriate Use of Group and Concurrent based on Clinical Appropriateness
  - Compliance with the group and concurrent therapy limit.
- Facilities whose beneficiaries experience inappropriate early discharge or provision of fewer services (e.g., due to the variable per-diem adjustment).
  - LENGTH OF STAY
  - COMMUNITY DC
  - READMISSION RATES
- Functional Outcomes
  - GG, labor, time

Quality Audit for Accuracy

- STEP 1: Obtain CASPER report: MDS Facility Level Quality Measure Report
  - Identify all QMs that are at or above the 75th percentile (comparison group national percentile)
- STEP 2: Obtain CASPER report: MDS Resident Level Quality Measure Report
  - Identify all residents who triggered the QM
- STEP 3: Determine which areas of MDS to audit for accuracy
- STEP 4: Review each resident's medical record to determine if MDS was coded correctly
- STEP 5: Add to your QAPI plan and Complete root cause analysis

QRP FY2020: Approved Measures Data Collection Began Oct. 1, 2018

Measure	
Change in Self Care	Numerator: GG0130A-H (Columns 1 & 3) Exclusions: A0310G, A2100, A2400, B0100, O0100K2, O0400B1–3, O0400C1–3 Covariates: A0900, B0700, B0800, C0500, C0900, C1310, G0600D, GG0100A & B, GG0110, GG0130A1–H1, H0100D, H0300, H0400, I0020, I0100, I0400, I1500, I2100, I2900, I4300, I4500, I4800, I4900, I5000, I5100, I5200, I5250, I5300, J2000, K0510A–B, M0300A–G, O0100J1, O0100M2, O0500I
Change in Mobility	Numerator: GG0170A-P (Columns 1 & 3) Exclusions: A0310G, A2100, A2400, B0100, O0100K2, O0400B1–3, O0400C1–3 Covariates: A0900, B0700, B0800, B1000, C0500, C0900, G0600D, GG0100B, C, & D, GG0110, GG0170A1–P1, H0300, H0400, I0020, I0100, I0400, I1500, I2000, I2100, I3900, I4300, I4500, I4800, I4900, I5000, I5100, I5200, I5800, I5900, I5950, I6000, J1700, J2000, K0510A–B, M0300A–G, O0100J1, O0100M2, O0500I

Audit GG MDS Accuracy

- Why?
  - PDPM Category Implications
    - PT
    - OT
    - Nursing
  - QRP
    - The IMPACT (Improving Medicare Post-Acute Care Transformation) Act of 2014 required standardized data collection across post-acute care settings: skilled nursing facilities (SNF), long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), and home health agencies (HHA). In response to the reporting requirements under the IMPACT Act, CMS established the SNF Quality Reporting Program (QRP). SNFs that do not submit the required measure data may receive a 2% reduction to their annual payment update (APU) for the applicable payment year. The measure cannot be calculated if the MDS item set is missing (e.g., PPS Part A Discharge assessment not submitted) or if the MDS item was not assessed (e.g., dashed).
  - Will be publically reported in 2020
    - Change in Self Care
    - Change in Mobility
    - Discharge Self Care
    - Discharge Mobility