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42 U.S. Code § 1395lll

Standardized post-acute care (PAC) assessment data for quality, payment, and discharge planning

(a) Requirement for standardized assessment data

(1) In general

The Secretary shall—

(A) require under the applicable reporting provisions post-acute care providers (as defined in paragraph (2)(A)) to report—

(i) standardized patient assessment data in accordance with subsection (b);

(ii) data on quality measures under subsection (c)(1); and

(iii) data on resource use and other measures under subsection (d)(1);

(B) require data described in subparagraph (A) to be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions, in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes; and

(C) in accordance with subsections (b)(1) and (c)(2), modify PAC assessment instruments (as defined in paragraph (2)(B)) applicable to post-acute care providers to—

(i) provide for the submission of standardized patient assessment data under this subchapter with respect to such providers; and

(ii) enable comparison of such assessment data across all such providers to whom such data are applicable.

(2) Definitions

For purposes of this section:

(A) Post-acute care (PAC) provider

The terms "post-acute care provider" and "PAC provider" mean—

(i) a home health agency;

(ii) a skilled nursing facility;

(iii) an inpatient rehabilitation facility; and

(iv) a long-term care hospital (other than a hospital classified undersection 1395ww(d)(1)(B)(vi) of this title).

(B) PAC assessment instrument

The term "PAC assessment instrument" means—

(i) in the case of home health agencies, the instrument used for purposes of reporting and assessment

with respect to the Outcome and Assessment Information Set (OASIS), as described in sections 484.55 and 484.250 of title 42, the Code of Federal Regulations, or any successor regulation, or any other instrument used with respect to home health agencies for such purposes;

(ii) in the case of skilled nursing facilities, the resident's assessment under section 1395i–3(b)(3) of this title;

(iii) in the case of inpatient rehabilitation facilities, any Medicare beneficiary assessment instrument established by the Secretary for purposes of section 1395ww(j) of this title; and

(iv) in the case of long-term care hospitals, the Medicare beneficiary assessment instrument used with respect to such hospitals for the collection of data elements necessary to calculate quality measures as described in the August 18, 2011, Federal Register (76 Fed. Reg. 51754–51755), including for purposes of section 1395ww(m)(5)(C) of this title, or any other instrument used with respect to such hospitals for assessment purposes.

(C) Applicable reporting provision

The term "applicable reporting provision" means—

(i) for home health agencies, section 1395fff(b)(3)(B)(v) of this title;

(ii) for skilled nursing facilities, section 1395yy(e)(6) of this title;

(iii) for inpatient rehabilitation facilities, section 1395ww(j)(7) of this title; and

(iv) for long-term care hospitals, section 1395ww(m)(5) of this title.

(D) PAC payment system

The term "PAC payment system" means—

(i) with respect to a home health agency, the prospective payment system under section 1395fff of this title;

(ii) with respect to a skilled nursing facility, the prospective payment system under section 1395yy(e) of this title;

(iii) with respect to an inpatient rehabilitation facility, the prospective payment system under section 1395ww(j) of this title; and

(iv) with respect to a long-term care hospital, the prospective payment system under section 1395ww(m) of this title.

(E) Specified application date

The term "specified application date" means the following:

(i) Quality measures

In the case of quality measures under subsection (c)(1)—

(I) with respect to the domain described in subsection (c)(1)(A) (relating to functional status, cognitive function, and changes in function and cognitive function)—

(aa) for PAC providers described in clauses (ii) and (iii) of paragraph (2)(A), October 1, 2016;

(bb) for PAC providers described in clause (iv) of such paragraph, October 1, 2018; and

(cc) for PAC providers described in clause (i) of such paragraph, January 1, 2019;

(II) with respect to the domain described in subsection (c)(1)(B) (relating to skin integrity and changes in skin integrity)—

(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2016; and

(bb) for PAC providers described in clause (i) of such paragraph, January 1, 2017;

(III) with respect to the domain described in subsection (c)(1)(C) (relating to medication reconciliation)—

(aa) for PAC providers described in clause (i) of such paragraph, January 1, 2017; and

(bb) for PAC providers described in clauses (ii), (iii), and (iv) of such paragraph, October 1, 2018;

(IV) with respect to the domain described in subsection (c)(1)(D) (relating to incidence of major falls)—

(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2016; and

(bb) for PAC providers described in clause (i) of such paragraph, January 1, 2019; and

(V) with respect to the domain described in subsection (c)(1)(E) (relating to accurately communicating the existence of and providing for the transfer of health information and care preferences)—

(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2018; and

(bb) for PAC providers described in clause (i) of such paragraph, January 1, 2019.

(ii) Resource use and other measures

In the case of resource use and other measures under subsection (d)(1)—

(I) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2016; and

(II) for PAC providers described in clause (i) of such paragraph, January 1, 2017.

(F) Medicare beneficiary

The term "Medicare beneficiary" means an individual entitled to benefits under part A or, as appropriate, enrolled for benefits under part B.