**Fact Sheet: Reset IMPACT Act to Account for COVID-19 Lessons on Post-acute Care**

**The Issue**

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 was enacted, in part, to develop a unified payment model for the post-acute care (PAC) field, recognizing that payment needed to be modernized for the four PAC settings – home health (HH) agencies, skilled nursing facilities (SNF), inpatient rehabilitation facilities (IRF), and long-term care hospitals (LTCH). However, the legislation could not account for the transformative changes implemented to the existing PAC payment systems following its passage. Further, Congress obviously did not anticipate the COVID-19 pandemic, which has placed a spotlight on the broad array of patient needs and clinical capabilities found across the PAC continuum. The pandemic has made clear the need to refresh the IMPACT Act mandate.

**PAC Role in COVID-19 Response**

- COVID-19 continues to place unprecedented strain on the entire health care system. This includes PAC providers, which treat patients with COVID-19, admit patients transferred from a referring hospital to create more space for those affected by the virus, and provide advanced care and/or extended-stays for PAC patients recovering from the virus.

- PAC patient care – especially in hotspots – includes LTCHs treating the highest-acuity patients with the virus, including those requiring ventilator care; LTCHs and IRFs treating subsequent recovery stages; hospital-based SNFs successfully supporting the pandemic response of their host hospitals; and HH agencies and others using telehealth to mitigate exposure for patients, clinical personnel and the community. The experience of freestanding SNFs is notably distinct, with a wide range of experiences, including many challenges with infection control and other issues.

**COVID-19 Lessons Regarding PAC**

- The pandemic highlights the uneven patient care abilities across the four PAC settings, with regard to physician leadership and oversight, the contributions of other specialists and clinicians, infection control reliability, and patient outcomes. These disparities are of greatest consequence for medically-complex patients with and recovering from COVID-19.

- These and other emerging lessons beg the question of whether a unified PAC payment system can accurately and reliably blend payments and other policies for these four settings – or even for the three institutional PAC settings – given their uneven roles, capabilities and outcomes. This concern is underscored by already-lingering doubts that a single payment system could accurately and reliably pay for the full range of PAC patients and services. In fact, the Medicare Payment Advisory Commission echoed this limitation during several public meetings in 2019.

**Resetting the IMPACT Act**

The PAC PPS development mandate and timeline established in the IMPACT Act, outlined below, must immediately be revisited and reset to reflect both new insights from the pandemic and the effect of recent transformative reforms of the existing PAC payment systems. Specifically, the reset should include:

- A report on the relative strengths and needed improvements for each PAC setting, as they pertain to COVID-19 as well as future pandemics;

- An assessment of the abilities of each PAC setting to prevent, mitigate and contain the intra-facility and community-spread of COVID-19 and similar infectious diseases;
• An evaluation of the accuracy and reliability of the IMPACT Act-mandated payment model relative to medically-complex patients with the virus, and other high-acuity patients; and

• A requirement that the new model incorporate the most recent data, including data that capture recent PAC payment reforms.

### Ongoing PAC Payment Reforms

**HH Reform.** In January 2020, a reengineered HH payment system was implemented, the patient-grouping payment model, which shifts resources from high-therapy to medically complex patients.

**SNF Reform.** In October 2019, a completely redesigned payment system was implemented for SNFs, the patient-driven payment model, which shifts resources from high-therapy to medically complex patients.

**IRF Reform.** The IRF payment system was materially updated in October 2019 by recalibrating the payment categories and weights.

**LTCH Reform.** In October 2015, the LTCH field launched a two-tiered payment model that pays far-lower rates for lower-acuity hospital patients, now one out of four cases. This reform continues to reduce overall LTCH volume and yield LTCH closures.

### Timeline of Key PAC Payment Reforms

**Oct. 2014:** IMPACT Act enacted:
- Build new PAC PPS payment model
- Align PAC quality and patient assessment measures
- Consistent COPs for PAC

**Oct. 2015:** LTCH site-neutral payment phase-in began

**Oct. 2018:** IMPACT Act 2-year quality data collection began

**Oct. 2019:** Recalibrated IRF PPS Implemented

**Jan. 2020:** Redesigned HH PPS Implemented

**Sept. 2020:** LTCH site-neutral payment phase-in complete

**2014** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **2023**

### Endnotes

1. Hospital-based SNFs, a small but important segment of the field, have had a different role in the COVID-19 response due to being co-located with a host hospital, which enables coordinated service delivery, streamlined communications and planning, sharing of resources (e.g., personal protective equipment), and joint infection control.

2. See page 221 of the September 2019 MedPAC meeting transcript, which includes Commissioner concerns about the ability of a single PAC PPS to be truly uniform, and questions whether available data can distinguish the degrees of clinical complexity across the broad array of PAC patients’ medical severity and needs.