



American Academy of
Physical Medicine and Rehabilitation

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POST-ACUTE CARE REFORMS TO ADVANCE PATIENT-CENTERED CARE

Delaying Implementation of the IMPACT Act

AAPM&R urges Congress to pass [The Resetting the IMPACT Act \(TRIA\) of 2021 \(H.R. 2455\)](#) to ensure that development of any unified post-acute care (PAC) payment system incorporates lessons learned from the COVID-19 pandemic.

This bipartisan legislation, introduced by Reps. Terri Sewell (D-AL) and Vern Buchanan (R-FL), would “reset and recalibrate” the implementation timeline for the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 to ensure that the Centers for Medicare and Medicaid Services (CMS) can incorporate patient and quality data that reflect the impact of COVID-19 and other recent changes to Medicare PAC payment.

Currently, Medicare pays for PAC services using separate payment systems for each setting of care (inpatient rehabilitation facilities, skilled nursing facilities, long-term care hospitals, and home health agencies). The IMPACT Act directed CMS and the Medicare Payment Advisory Commission (MedPAC) to begin developing models for a “unified” payment system, using at least two years’ worth of patient and quality measure data for each setting. Since its enactment, however, CMS has implemented significant payment changes to the skilled nursing facility and home health settings, and the COVID-19 pandemic has upended the provision of post-acute care.

Enacting TRIA would help ensure that any unified PAC payment proposal accounts for current data and reflects the reality of the PAC system, including the impact of COVID-19.

Enhancing the “Three- Hour Rule”

AAPM&R urges Congress to pass the [Access to Inpatient Rehabilitation Therapy Act](#), soon to be introduced in the 117th Congress, to restore physician judgment to IRF care and ensure that patients can access the rehabilitation services they need.

CMS requires that Medicare beneficiaries need a “relatively intense” course of rehabilitation treatment to qualify for an inpatient rehabilitation facility (IRF) stay. CMS defines “relatively intense” as three hours of skilled therapy per day, five days per week, the so-called, “three-hour rule”. In 2010, CMS revised the IRF regulations and narrowed the three-hour rule so that only *physical therapy, occupational therapy, speech therapy*, and/or *orthotics and prosthetics* are countable toward the three-hour rule. Other skilled therapies including recreational therapy, psychological services, respiratory therapy, and neuropsychological services are no longer counted, limiting their availability in many rehabilitation hospitals.

This bill would maintain the explicit focus on the four therapies listed above, while adding flexibility for the physician and rehabilitation team to determine the appropriate mix of skilled services to provide a more tailored treatment plan to meet individual patient needs. During the public health emergency, the three-hour rule has been waived entirely for IRFs. Data from 2020 demonstrates that despite this broad flexibility, IRF admissions have not increased, nor has there been a significant decrease in therapy minutes provided in IRFs. It is critical to ensure that flexibility continues after the end of the PHE so patients can access the most appropriate, individualized care for their conditions.

Enacting the Access to Inpatient Rehabilitation Therapy Act in the 117th Congress will help ensure IRF patients can access the medically appropriate care they need.

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