April 23, 2026

Submitted Electronically

Michael E. Chernew, Ph.D.
Chair
Medicare Payment Advisory Commission

Re: American Medical Rehabilitation Providers Association's Comments on MedPAC's April 2026 Public Meeting

Dear Dr. Chernew, MedPAC Commissioners, and Staff:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA) and our 800+ member inpatient rehabilitation hospitals, we appreciate the opportunity to provide our response to MedPAC's April 2026 meeting session regarding Medicare Advantage (MA) enrollment and the corresponding impact on hospitals' and post-acute care providers' finances. AMRPA has long urged MedPAC to more carefully assess the impact of MA growth on inpatient rehabilitation facilities – particularly with respect to utilization and denial rates compared to the fee-for-service (FFS) program. We believe this session was an important first step in this effort, and we urge MedPAC to expand on this work in the 2026/2027 cycle.

During the April session, AMRPA appreciated MedPAC's assessment of the rapid growth of MA enrollment and the ways MA plan practices affect hospitals, post-acute care providers, and beneficiary access to medically necessary care. For inpatient rehabilitation facilities (IRFs), however, the April presentation raises serious concerns beyond provider finances. MedPAC's own data shows that MA's share of Medicare IRF days remains far below overall MA market penetration. In 2024, median MA market penetration was 55 percent, while the median MA share of Medicare IRF days was only 24 percent. This 30-percentage-point gap strongly suggests that MA enrollees continue to use IRFs at substantially lower rates than traditional Medicare beneficiaries, suggesting alarming and widespread utilization restriction tactics and access gaps among patients in need of medical rehabilitation.

This concern is reinforced by the staff and Commission's subsequent discussion of MA plan incentives. MedPAC recognizes that MA plans may curtail post-acute care spending by steering patients to lower-cost settings, negotiating lower payment rates, and reducing utilization. While AMRPA supports efforts to ensure beneficiaries receive care at the most cost-effective *and* clinically appropriate setting, the differences between MA penetration and MA IRF use raise serious questions about whether plans are prioritizing the former at the expense of optimal patient care and outcomes. Such concerns are supported by a recent study finding[1] that MA enrollment is "associated with lower IRF use...coupled with a concerning increase in mortality, including an 11.9% relative increase in 90-day mortality for hip

[1] D. T.Lake, V.Mor, D. C.Grabowski, A. N.Trivedi, and P. L.Gozalo, "Association of Medicare Advantage Enrollment With Post-Acute Care Use and Associated Patient Outcomes," Journal of the American Geriatrics Society (2026): 1–9, **https://doi.org/10.1111/jgs.70432**.

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fracture patients." The same study also suggested that the "...adverse mortality finding was not uniform across markets; it was concentrated entirely in markets with high baseline IRF use, where we observed a 22.3% relative increase in 90-day mortality for hip fracture and an 18.0% relative increase in 90-day mortality for stroke." The study suggested that MA enrollment may therefore be contributing to "the disruption of a stable local PAC ecosystem," such that when MA plans divert higher-acuity patients to SNFs, the MA program "**may create a dangerous mismatch between patient needs and provider capabilities**" (emphasis added).

Based on these and other similar findings, AMRPA has long cautioned MedPAC and other policymakers against treating IRFs and skilled nursing facilities (SNFs) as interchangeable settings or bluntly assessing patients' post-acute care needs based only on primary condition. We were highly concerned, therefore, that MedPAC's assessment of MA utilization did not incorporate these past AMRPA recommendations. As MedPAC is aware, IRFs are fully licensed hospitals or hospital units that provide intensive, interdisciplinary rehabilitation under the direct supervision of rehabilitation physicians, with significant medical management of patients' underlying and co-existing conditions. In assessing whether a patient is appropriate for the IRF-level of care, it is imperative to consider that patients with similar diagnoses may have very different medical complexity, functional status, rehabilitation potential, caregiver support, and need for physician-led interdisciplinary care. MedPAC analysis recently supported this need for nuance by highlighting that MA IRF patients were more likely to be admitted for stroke, amputations, spinal cord dysfunction, and traumatic brain dysfunction, and that patients with these conditions may have more limited treatment options in other post-acute care settings. If MA beneficiaries reach IRFs primarily in the most obvious or severe clinical circumstances, while other patients who require IRF-level care are diverted to lower-intensity settings, aggregate IRF use patterns may mask meaningful access restrictions.

AMRPA is also concerned that MA policies may delay timely transfer to IRF care. The most recent public meeting discussion and presentation materials indicate that MA beneficiaries had longer acute care hospital stays than comparable FFS beneficiaries, with the largest gap for patients whose intended discharge destination was an IRF. MA hospital stays were 11.2 percent longer overall, but 32.3 percent longer for patients intended for discharge to an IRF. AMRPA members consistently report that MA plans delay and deny physician and care team-recommended discharges to IRFs, forcing patients to remain in their acute care beds longer while denials are appealed (or, even more problematically, get discharged to lower-acuity settings due to hospital backlogs). We were disappointed that these tactics were not meaningfully considered during the MA utilization discussion.

For these reasons, **AMRPA urges MedPAC to more meaningfully assess MA and IRF access rates.** Specifically, MedPAC should examine whether and to what extent MA plan tactics – such as prior authorization and insufficient IRF coverage in plan networks - are reducing access to medically necessary IRF care. We also encourage MedPAC to consider a Commissioner's suggestion that IRFs be added to the MA network adequacy standards and encourage adopting such policy as a recommendation in future work.

AMRPA also urges MedPAC to avoid interpreting lower MA IRF use (typically in favor of SNF placements) as inherently positive or efficient without corresponding patient outcome analysis. As AMRPA has previously emphasized in our MedPAC correspondence, a comparison of IRF and SNF quality outcome data[2] demonstrates that IRFs report a lower rate of potentially preventable hospital readmissions 30 days after discharge, a higher rate of successful return to home or community, lower rates for falls with major injury and pressure ulcers/injuries that are new or worsened, and a higher percentage of patients that meet or exceed expectations for functional status at discharge. A lower-cost post-acute placement is simply not higher value if it results in worse functional recovery, preventable complications, or hospital readmission. We therefore recommend that future MedPAC analysis of MA enrollment and post-acute care impacts should incorporate outcomes such as functional improvement, discharge to community, readmissions, complications, mortality, and the need for subsequent institutional care.

In addition, **AMRPA asks MedPAC to acknowledge the limitations of its April IRF analysis**. The Commission did not apply the same regression framework to IRFs that it applied to SNFs and home health agencies because many IRFs are hospital-based. As a result, the IRF discussion relied on descriptive volume and patient-mix data. That limitation makes the 55 percent MA market penetration versus 24 percent MA share of IRF Medicare days finding especially important, but it also underscores the need for further IRF-specific work before MedPAC draws broader conclusions about MA's impact on IRF access or finances.

Finally, **AMRPA encourages MedPAC to engage directly with IRF providers, rehabilitation physicians, discharge planners, patients, and caregivers to better understand how MA practices operate in real time and some of the novel practices that IRFs have adopted to address egregious plan behavior**. AMRPA members can provide examples of delayed authorizations, inappropriate denials, peer-to-peer burdens, shortened stays, limited networks, and contracting challenges that are often not visible in claims or cost report data. While we appreciate MedPAC's recent engagement with numerous IRF providers to discuss MA enrollment and its corresponding impact on IRF finances, we believe that these broader discussions could provide for more meaningful Commission discussion in future cycles.

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In closing, AMRPA believes MedPAC's April 2026 findings highlight a critical and growing issue for Medicare beneficiaries. As MA enrollment continues to expand, MA beneficiaries' use of IRF care remains disproportionately low. MedPAC's own data showing 55 percent median MA market penetration compared to only 24 percent median MA share of Medicare IRF days should prompt further examination of whether MA plan practices are restricting access to IRF-level care.

[2] available at https://data.cms.gov/provider-data/

As always, AMRPA would welcome the opportunity to host MedPAC staff and Commissioners on IRF tours or facilitate interviews with AMRPA hospital leaders, rehabilitation physicians, and discharge planners. Should you have any questions related to our concerns or recommendations, please contact Kate Beller, AMRPA President, at KBeller@amrpa.org, or Troy Hillman, AMRPA Director of Quality and Health Policy, at THillman@amrpa.org.

Sincerely,

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