

October 2, 2026

Amol S. Navathe, M.D., Ph.D.
Chair
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, DC 20001

Re: Examining Use of Post-Acute Care Services by Beneficiaries in Fee-for-Service Medicare and Medicare Advantage, September 2026 Meeting

Dear Chairman Navathe:

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations, including inpatient rehabilitation facilities (IRFs) and long-term care hospitals (LTCHs), and our clinician partners, the American Hospital Association (AHA) appreciates the Medicare Payment Advisory Commission's (MedPAC's) examination of differences in post-acute care use between beneficiaries enrolled in Medicare Advantage (MA) and fee-for-service (FFS) Medicare. This work is both timely and important.

Hospitals and health systems continue to report that certain MA organizations use prior authorization, restrictive coverage practices and inadequate post-acute care networks in ways that delay or deny access to medically necessary care. A clearer understanding of how these practices affect where patients receive care, how long they remain in acute care hospitals and what outcomes they experience is essential to protecting them and ensuring appropriate oversight of the MA program.

Indeed, MedPAC's preliminary findings reinforce concerns that the AHA has repeatedly shared with the Commission, Congress, the Centers for Medicare & Medicaid Services (CMS), the Department of Health and Human Services Office of Inspector General and other policymakers. In particular, MedPAC found that MA beneficiaries used less post-acute care overall than FFS beneficiaries and were less likely to receive IRF care. MedPAC also found that acute care hospital stays were longer for MA beneficiaries than FFS beneficiaries regardless of the post-acute care destination. These patterns are consistent with hospitals' and health systems' experiences: MA prior authorization and utilization management practices delay hospital discharge and restrict access to the level of post-acute care recommended by the treating clinical team.



MEDPAC'S FINDINGS SUPPORT PROVIDER-REPORTED CONCERNS

The magnitude and consistency of the differences between MA and FFS care patterns warrant close attention. For example, MedPAC found that in 2023, there were 14 IRF stays per 1,000 for FFS beneficiaries, but only five per 1,000 for MA enrollees. It found that there were two LTCH stays per 1,000 for FFS beneficiaries, but only one per 1,000 for MA enrollees. Among all beneficiaries, 1.2% of FFS beneficiaries used IRF care compared with only 0.4% of MA enrollees. MedPAC further found that pathways including IRF care were less common among MA enrollees. These results align with AHA member reports and prior analyses indicating substantially lower use of hospital-level post-acute care among MA beneficiaries.

MedPAC's finding that MA beneficiaries' acute care hospital stays were longer than FFS stays across every post-acute destination is also particularly significant. The median acute care stay for beneficiaries discharged to an IRF was nine days for MA enrollees compared with six days for FFS beneficiaries. For beneficiaries discharged to an LTCH, the medians were 21 and 13 days, respectively. These results are consistent with an AHA claims analysis finding longer referring-hospital stays for MA beneficiaries discharged to LTCHs, IRFs and skilled nursing facilities (SNFs). They also mirror what hospitals experience operationally: MA beneficiaries who are medically ready for discharge remain in acute care beds while plans lag in processing prior authorization requests, conducting peer-to-peer reviews and adjudicating appeals.

Delays such as this can adversely affect beneficiaries while also straining hospital capacity. A beneficiary who remains in an acute care hospital awaiting authorization may not receive in a timely manner the specialized rehabilitation or extended hospital-level services that treating clinicians have determined are needed. At the same time, delayed transitions occupy acute care beds and clinical resources that hospitals need to serve other patients in their communities. Accordingly, MedPAC's continued work should examine not only whether MA beneficiaries use less post-acute care, but also whether and how utilization management practices contribute to longer acute care stays, delayed initiation of rehabilitation, avoidable readmissions and other adverse outcomes.

IRFS, LTCHS AND SNFS ARE NOT INTERCHANGEABLE CARE SETTINGS

As MedPAC proceeds, the AHA urges the Commission to maintain a clear distinction among post-acute settings. Although IRFs, LTCHs and SNFs all furnish post-acute services, they do not provide the same level, intensity or type of care. IRFs and LTCHs are hospitals. IRFs furnish intensive, coordinated rehabilitation under close medical supervision and 24-hour nursing care for patients who require and can benefit from a hospital-level rehabilitation program. LTCHs treat medically complex patients who require extended hospital-level care, including prolonged mechanical ventilation, complex respiratory care, dialysis, treatment of serious infections or advanced wound

care. SNFs provide an essential benefit, generally focusing on a lower level of medical and rehabilitative intensity.

Hospitals and health systems report that certain MA plans routinely attempt to redirect patients recommended for IRF or LTCH admission to a SNF, even when the treating team has determined that a SNF cannot safely or effectively meet the patient's needs. This is simply not appropriate. Steering a patient to a SNF in place of an IRF or LTCH substitutes a lower level of care than that prescribed by the treating clinicians. It may interrupt recovery, increase the risk of clinical deterioration and readmission, and ultimately increase burdens on beneficiaries, families and the broader delivery system.

PRIOR AUTHORIZATION, COVERAGE CRITERIA AND REVIEWER EXPERTISE

The AHA also encourages MedPAC to examine in detail MA utilization management practices themselves, and not only their outcomes. Hospitals report that certain plans overrule treating clinicians, apply coverage criteria that are more restrictive than traditional Medicare, provide incomplete denial rationales, and use reviewers who lack relevant expertise in rehabilitation or the complex conditions treated in LTCHs. These practices make it difficult for patients and providers to understand the basis for a denial, submit an effective appeal and obtain timely access to covered benefits.

While CMS has clarified that MA plans must follow traditional Medicare coverage criteria for basic benefits as well as strengthened requirements governing prior authorization and clinical review, hospitals and health systems continue to report persistent delays and denials. It seems that the MA plans simply are not following this guidance. As such, we recommend that MedPAC continue to conduct provider, beneficiary and plan interviews, which would offer an important opportunity to assess implementation in practice. We further recommend that interviews include acute care hospital discharge planners, treating physicians, IRF and LTCH clinicians, beneficiaries, and family caregivers. Their experiences are critical to understanding how prior authorization operates at the point of care and whether a plan's stated policies align with actual decision-making.

We also urge MedPAC to examine the qualifications of plan reviewers, the specificity and completeness of denial notices, the criteria cited in adverse determinations, the time from an initial request to final authorization, reversal rates on appeal and the clinical consequences of delayed or denied care. The Commission should consider whether plan-level reporting is sufficiently detailed to identify patterns by requested setting, reason for denial, reviewer specialty, processing time and outcome.

NETWORK ADEQUACY AND MEANINGFUL ACCESS TO COVERED BENEFITS

Prior authorization is not the only barrier affecting access. Current MA network adequacy standards do not specifically require the inclusion of IRFs and LTCHs. AHA

members report that some plans decline to contract with these providers or assert that SNFs can meet beneficiaries' rehabilitation or complex-care needs. When a plan lacks an adequate network of hospital-level post-acute providers, coverage of the benefit may be illusory even when a beneficiary meets Medicare coverage requirements.

We therefore encourage MedPAC to assess whether MA networks provide timely, meaningful access to the full continuum of covered post-acute services. This work should examine the availability of in-network IRF and LTCH care by market, the distances beneficiaries must travel, the frequency with which plans authorize out-of-network care, and whether network limitations contribute to longer acute care stays or placement in a setting that does not match the treating team's recommendation.

RECOMMENDATIONS FOR CONTINUED MEDPAC WORK

The AHA strongly encourages MedPAC to continue its important MA-related work. As the Commission refines its analysis, we recommend that it:

- Adjust comparisons for beneficiary characteristics while also stratifying results for clinically meaningful populations, including beneficiaries with significant functional impairments, complex medical needs, prolonged ventilation, and dual eligibility for Medicare and Medicaid.
- Examine outcomes associated with different post-acute settings, including mortality, readmissions, emergency department use, functional improvement, successful community discharge and total episode spending.
- Analyze the time between acute care discharge readiness, prior authorization submission, plan determination and transfer to the post-acute setting, as well as the relationship between authorization delays and acute care length of stay.
- Compare the treating clinician's recommended post-acute setting with the setting authorized by the MA plan and the setting ultimately used, including instances in which a plan directs an IRF- or LTCH-appropriate patient to a SNF.
- Evaluate denial rationales, use of internal coverage criteria, qualifications of plan clinical reviewers, peer-to-peer and appeal processes, and rates at which initial denials are overturned.
- Assess the adequacy of MA post-acute networks, with particular attention to access to IRFs and LTCHs.
- Interview hospital discharge planners, treating clinicians, post-acute providers, beneficiaries and family caregivers, in addition to MA plan representatives.

The AHA thanks MedPAC for undertaking this analysis and for planning additional quantitative and qualitative work. The Commission's preliminary data confirm concerns raised by hospitals and health systems and provide a strong foundation for further investigation. Indeed, the AHA would be pleased to assist MedPAC by sharing additional data, provider experiences and patient examples. Please contact me if you

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have questions or have a member of your team contact Jonathan Gold, AHA's senior associate director for post-acute payment policy, at (202) 626-2368 or jgold@aha.org.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development

Cc: Paul Masi, M.P.P.
MedPAC Commissioners