



September 18, 2026

Submitted Electronically

Amol S. Navathe, M.D., Ph.D.
Chair
Medicare Payment Advisory Commission

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

Dear Dr. Navathe, MedPAC Commissioners, and Staff:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA) and our 800+ member inpatient rehabilitation hospitals and units, we look forward to engaging with the Medicare Payment Advisory Commission (MedPAC) – particularly the Commissioners serving their first term – as the Commission initiates its 2026/2027 cycle. As we have previously discussed with Commission staff, AMRPA believes that Medicare Advantage (MA) coverage and utilization trends in the post-acute care sector are a critical component of MedPAC's fee-for-service (FFS) analysis (particularly providers' finances), and we are pleased to see that the Commission is carrying forward this line of analysis from last session.

During the September public meeting, AMRPA appreciated MedPAC's assessment of the rapid growth of MA enrollment and the ways MA plan practices affect both short-term acute care hospitals (STACHs) and post-acute care (PAC) providers, including with respect to both length-of-stay in the STACH and how beneficiaries utilize post-acute care (the "PAC pathways") after discharge. However, AMRPA reiterates several of our concerns from last cycle, including how the discrepancies between inpatient rehabilitation facility (IRF) utilization in MA and FFS are being interpreted by a number of MedPAC staff and Commissioners about the value of IRF care and the perceived interchangeability across PAC settings.

Our comments below focus on our substantive concerns with several inaccuracies and mischaracterizations of the IRF field that were asserted during the session, as well as our analytical recommendations as MedPAC continues to refine this analysis. We look forward to engaging with the Commission as it addresses these and other stakeholder recommendations during future sessions:

I. Staff & Commissioner Discussion Reinforces the Need for Greater Understanding of the PAC Spectrum, Particularly IRF Services

One of AMRPA's top policy priorities involves MA reform. Our work is driven by government oversight reports, member anecdotes, and AMRPA surveys showing the glaring

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utilization gaps for IRF services between MA and Medicare FFS, as well as the host of corresponding issues – including delayed referrals and post-discharge clawbacks. A recent Office of Inspector General (OIG) report affirmed AMRPA member concerns, asserting that “financial incentives may be partially driving higher denial rates” on the part of major MA plans.

For these reasons, AMRPA was highly concerned that segments of the Commissioner discussion included interpretations that lower IRF utilization in MA is possible evidence that IRF utilization in FFS is unnecessary or “low value.” Some of the discussion suggested that beneficiaries who were referred for IRF services can instead receive care in skilled nursing facilities (SNFs) and “do just fine.” Other Commissioners appropriately pushed back, noting that the fact that beneficiaries “could” receive care at one setting fails to account for the fact that beneficiaries can do “better” – and likely experience better outcomes and incur lower costs-of-care in the long-term – by being treated in the setting that is specifically equipped for their specific PAC needs.

These exchanges reinforce a concern AMRPA has raised over multiple meeting cycles: IRFs and SNFs should not be treated as interchangeable settings. IRFs are fully licensed hospitals or hospital units providing intensive, interdisciplinary rehabilitation under physician supervision, along with significant medical management of patients’ underlying and co-existing conditions. Patients with similar diagnoses may have very different medical complexity, functional status, rehabilitation potential, and need for physician-led interdisciplinary care. We therefore are reattaching a comparison chart in our appendix that highlights the key differentiating factors across all the post-acute care settings and how such factors drive very different outcomes for patients; we believe these differences strongly counter past MedPAC commentary that patients in areas without IRFs are able to access “substitutable” care at SNFs in the same marketplace and any other presumptions of “interchangeability” across two entirely different provider types. We urge MedPAC to incorporate this information into future analyses and public meeting commentary.

AMRPA further notes that assertions of “unnecessary” IRF care being provided to FFS beneficiaries are inconsistent with recent results from the IRF Review Choice Demonstration (RCD). Among the four states currently subjected to the RCD, which includes pre-claim review of 100% of FFS admissions by Medicare Administrative Contractors (MACs), affirmation rates range from 88% during the first three months in California, to 90% during Cycle 3 in Alabama, to 97.41% during the first four months in Texas, to 98.89% during Cycle 3 in Pennsylvania. These strong affirmation rates indicate that IRF admissions are meeting medical necessity, documentation, and coverage requirements for IRF payment for the vast majority of admitted patients – countering Commissioner and staff assertions that IRFs are admitting inappropriate patients. Even more notable, AMRPA members are reporting strong overturn rates for the relatively small group of non-affirmed cases.

AMRPA therefore reiterates our past recommendations regarding the value of IRF care in the Medicare program, and we strongly agree with a Commissioner suggestion to apply a stronger clinical lens and more clearly explain what services are furnished in each post-acute setting. AMRPA would welcome the opportunity to provide Commissioners and

staff with an IRF-specific clinical briefing, arrange facility visits, and facilitate discussions with rehabilitation clinicians and hospital leaders to help provide additional color on the differences between PAC settings. We also encourage MedPAC to replicate AMRPA’s PAC comparison chart in future Commissioner- and public-facing materials.

II. AMRPA Strongly Opposes Certain Policy Recommendations Stemming from MA and FFS PAC Utilization Rates

In addition to the commentary around “low value” PAC care, which AMRPA strongly disagrees with, AMRPA was alarmed by renewed suggestions by a handful of Commissioners and staff that differences in IRF and SNF utilization support “site-neutral” payment policies. First, as a technical point, “site-neutral” models apply when patients receive the same service in different settings (typically driven entirely by cost considerations). That premise has never applied to models involving IRFs and SNFs. While IRFs and SNFs are two entirely different settings – at the most obvious level, IRFs are licensed as hospitals, whereas SNFs are not (please see the aforementioned section for further detail on this point), these two types of care settings provide different types of services. As one Commissioner explained, and as noted in the attached appendix, different post-acute settings furnish fundamentally different clinical services, making traditional site-neutral concepts inapplicable to this line of MedPAC work.

As AMRPA has previously outlined in our MedPAC correspondence, the fact that some diagnoses appear in both IRFs and SNFs does not establish that the patients, services, or expected outcomes are equivalent. The clinically appropriate post-acute care setting depends on a range of factors, including medical complexity, functional deficits, rehabilitation potential, tolerance for intensive therapy, and need for physician oversight. As MedPAC itself has recognized, better and more robust outcomes data are essential before any major payment reforms are contemplated, particularly reforms that have cross-sector components. Without such evidence, conclusions about the relative value or necessity of IRF care risk overlooking meaningful differences in patient needs, treatment intensity, and outcomes across settings.

For similar reasons, we urge Commissioners to reconsider any assertions that lower initial payment be equated with greater value. AMRPA has previously highlighted outcome differences between IRFs and SNFs, including higher successful return-to-community rates and lower potentially preventable 30-day readmission rates for IRFs, all of which must be taken into account in any discussion regarding value. AMRPA strongly aligns with a Commissioner’s comment that “MA plans [may] have targeted the IRF sector because they’re focused on cost as opposed to value,” and, in the case of IRFs and other services, “sometimes you have high-cost, high-value services” that are particularly vulnerable to short-term cost-saving incentives. With these dynamics in mind, AMRPA urges MedPAC to reconsider how cross-sector PAC payment reform would impact beneficiary access to medically necessary care and the corresponding impact on outcomes.

In sum, before considering any cross-sector PAC payment policy, MedPAC should first establish that the patients being compared are clinically comparable, that the services furnished are comparable, and the alternative settings produce comparable short- and

long-term outcomes. AMRPA does not believe the available evidence supports consideration of site-neutral PAC payment policies between IRFs and SNFs. This is consistent with MedPAC's inability to achieve consensus on site-neutral payment proposals between these two post-acute care settings discussed in depth by the Commissioners in recent years.

III. As MedPAC Refines its MA PAC Utilization Analysis, Staff Must Take Prior Authorization Delays and Downstream Outcomes into Account

Finally, while AMRPA appreciates MedPAC's exploration of how Medicare beneficiaries use PAC across payers, we believe it is essential that this analysis take into account how various incentives in the MA and traditional FFS programs directly impact care delivery across the program. As AMRPA has long discussed with MedPAC, we believe these dynamics are especially important to monitor and analyze for IRF providers, as AMRPA members continually report serious issues with unnecessary delays and inappropriate denials rendered by MA plans. We also applaud MedPAC's stated intention to supplement its existing work with results that are adjusted for beneficiary characteristics and from additional interviews with providers.

As MedPAC augments its analysis, AMRPA further urges MedPAC to more closely examine the longer STACH length-of-stay for MA beneficiaries and how this impacts longer-term outcomes, as well as whether this is correlated with ultimate PAC pathways that include more PAC stays (in different settings). MedPAC's finding that the median acute care stay was nine days for MA enrollees compared with six days for FFS beneficiaries is consistent with AMRPA reports, and we believe these trends must be further examined through the lens of STACH backlog and costs, as well as longer-term beneficiary PAC utilization following these delays.

AMRPA therefore recommends that MedPAC examine authorization timelines, acute care days associated with authorization or appeals, denial and ultimate approval rates, and downstream outcomes such as functional improvement, readmissions, mortality, and subsequent institutional care. We also encourage MedPAC to continue to build on its PAC pathways analysis, including a comparison of the average pathway of patients who initially receive IRF care versus those who receive their initial PAC care at another site and the corresponding estimated cost differences.

In closing, AMRPA applauds MedPAC for continuing to examine how MA utilization and coverage impacts beneficiary care and PAC provider finances. For the reasons outlined above, however, we urge MedPAC to be diligent and exercise caution in how it interprets disparities between FFS and MA PAC utilization, particularly for the IRF sector. As MA enrollment continues to expand, MA beneficiaries' use of IRF care remains disproportionately low. Given IRFs' distinct role in the PAC spectrum and our members' inherent focus on functional recovery, we encourage MedPAC to take a more nuanced view of these access gaps and how they may be driving PAC pathway differences and other long-term outcomes. We also

caution MedPAC against contemplating any payment reforms that inaccurately assume neutrality across PAC sites and places at risk access to medically necessary care.

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. If 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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Appendix: Comparisons Across Post-Acute Care Settings (IRF, SNF, LTCH, HH)
Initially Shared with MedPAC in December 2024

	INPATIENT REHABILITATION FACILITY (IRF)	SKILLED NURSING FACILITY (SNF)	LONG-TERM ACUTE CARE HOSPITAL	HOME HEALTH CARE
HOSPITAL-LEVEL CARE	YES	NO	YES	NO
INTENSITY OF CARE	Intensive, 24-hour-a-day, interdisciplinary rehabilitation care that is provided under the direct supervision of a physician	Daily skilled nursing or rehabilitation services	Extended medical and rehabilitative care for patients with complex medical needs resulting from a combination of acute and chronic conditions	Skilled nursing care and rehabilitation therapy, as well as some limited assistance with daily tasks designed to assist the patient in living in his or her own home
PHYSICIAN INVOLVEMENT & REHABILITATION EXPERIENCE REQUIREMENTS	• Rehabilitation physician required (specialized training & experience) • Responsible for overall plan of care and lead weekly interdisciplinary team meetings • Three face-to-face visits by physician required every week¹ • 24/7 physician coverage with daily visits typical	• No requirement for physician to have rehabilitation experience • Physician determines whether patient needs therapy • Physician visit required only once every 30 days for first 90 days, then every 60 days after	• No requirement for physician to have rehabilitation experience • Physician focus is primarily on medical management • Physician visits at least once a day • 24/7 physician coverage with daily rounding typical	• No requirement for physician involvement • A doctor or other health care provider must have a face-to-face visit before certifying need for home health services. • A doctor or other health care provider must order the care to be provided

¹ Beginning with the second week of admission to the IRF, a non-physician practitioner may conduct 1 of the 3 required face-to-face visits per week.

	INPATIENT REHABILITATION FACILITY (IRF)	SKILLED NURSING FACILITY (SNF)	LONG-TERM ACUTE CARE HOSPITAL (LTCH)	HOME HEALTH CARE
INTENSITY & TYPES OF THERAPEUTIC INTERVENTIONS	• General requirement for 3 hours/day, 5 days a week intensive interdisciplinary therapy (OT, PT, SLP, O&P). • Expectation that patient actively participates and benefits from therapies throughout IRF stay.	• Therapy provided based upon physician determination. • No requirement for specific number of hours per day. • No requirement for interdisciplinary therapy to be provided.	• Therapy is provided but primary focus is medical management of complex medical needs. • No requirement for specific number of hours per day. • No requirement for interdisciplinary therapy to be provided.	• Therapy is provided based upon orders from doctor or other health care provider after any needed consultation with a qualified therapist. • Duration and course of treatment is based upon qualified therapist's assessment of the beneficiary's function.
NURSING INVOLVEMENT & EXPERIENCE REQUIREMENTS	Registered nurses are present on a continuous basis and commonly have specialty certification in rehabilitation nursing.	Rehabilitation nurses are required to be on site for a minimum of 8 hours per day. Skilled nursing care provided daily.	Nursing provided consistent with hospital-level of care for medical management of complex medical needs.	Part-time or intermittent skilled nursing care from a registered nurse or LPN (supervised by RN). Fewer than 8 hours a day and 28 hours per week.

	INPATIENT REHABILITATION FACILITY (IRF)	SKILLED NURSING FACILITY (SNF)	LONG-TERM ACUTE CARE HOSPITAL (LTCH)	HOME HEALTH CARE
SUCCESSFUL RETURN TO COMMUNITY PERCENTAGE	66.95%	50.57%*	18.05%	Not Reported
RATE OF POTENTIALLY PREVENTABLE HOSPITAL READMISSIONS 30 DAYS AFTER DISCHARGE	8.90%	10.72%*	20.09%	4.1%
RATE OF POTENTIALLY PREVENTABLE HOSPITAL READMISSIONS DURING STAY	4.75%	23.7%*†	Not Reported	10.8%
PERCENTAGE OF STAYS WHERE CURRENT MEDICATION LIST IS PROVIDED TO THE RESIDENT, FAMILY, AND/OR CAREGIVER AT FINAL DISCHARGE	98.41%	96.15%*	89.26%	91.13%

Values above represent national average performance for all Medicare cases as displayed in provider data files available via <https://www.medicare.gov/care-compare/> for the September 2025 publications.

*Only the Short-Stay SNF measure values included as these represent the closest comparison to other post-acute care providers.

†Short Stay SNF measure is not specific to “Potentially Preventable Readmissions” as it is labelled as “Percentage of short-stay residents who were re-hospitalized after a nursing home admission”.