Federation of American Hospitals

Charlene K. MacDonald
President and CEO

November 3, 2026

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

Submitted electronically via meetingcomments@medpac.gov

Re: Post-acute care use in fee-for-service Medicare and Medicare Advantage (September 4, 2026, public meeting session)

Dear Dr. Navathe and Members of the Commission:

The Federation of American Hospitals (FAH) appreciates the opportunity to comment as the Medicare Payment Advisory Commission (MedPAC) examines how growing Medicare Advantage (MA) enrollment affects hospitals, post-acute care (PAC) providers and the beneficiaries they serve. FAH represents more than 1,000 leading tax-paying hospitals and health systems across 46 states, Washington, DC and Puerto Rico. Our members operate the acute care hospitals where post-acute placement decisions are made, as well as the inpatient rehabilitation facilities (IRFs) and long-term care hospitals (LTCHs) that receive those patients. Our members' experience in both acute and post-acute care can help inform the Commission's examination of post-acute care use. As this work is still in its early stages, FAH urges the Commission to carefully consider the limits of the current data and offers questions we believe should guide further analysis.

IRFs and LTCHs Provide Hospital-Level Care That Helps Beneficiaries Recover and Return Home

As the Commission considers these questions, FAH believes it is important to recognize the distinct and important role that IRFs and LTCHs play in Medicare's continuum of care. Both settings provide hospital-level care. IRFs offer intensive, physician-led interdisciplinary rehabilitation to beneficiaries recovering from conditions such as stroke, brain and spinal cord injuries and complex orthopedic injuries, helping them regain the mobility and self-care function needed to return home and live independently. In a national study of nearly 100,000 Medicare beneficiaries with stroke, IRF care was associated with substantially greater improvement in mobility and self-care than SNF care, and the difference remained after accounting for patient, clinical and facility characteristics.[1] Even among IRF cases with conditions that do not count toward the compliance threshold, the Commission's own analysis found that 73.1 percent of IRF patients were discharged to the community, compared with 55.8 percent of comparable SNF patients.[2] LTCHs serve chronically critically ill beneficiaries, including those who require prolonged mechanical ventilation following an intensive care unit stay, and Congress reserves the standard LTCH payment rate for patients with these intensive clinical needs. .[3] In helping patients recover function and transition to lower levels of care, IRFs and LTCHs can support beneficiaries in regaining independence and, where possible, avoiding long-term institutional care. FAH urges MedPAC to continue to focus on outcomes such as functional recovery and return to the community alongside utilization and spending as the Commission's work continues.

Lower Post-Acute Care Use in MA Does Not Necessarily Demonstrate Greater Efficiency

The Commission's September findings show that beneficiaries in fee-for-service (FFS) Medicare used more post-acute care than MA beneficiaries in every setting in 2023. The difference was largest for IRF care, used by 1.2 percent of FFS beneficiaries and 0.4 percent of MA beneficiaries. MedPAC staff cautioned that these figures are unadjusted and that levels of use do not indicate whether care was appropriate.[4] FAH agrees and appreciates the Commission's commitment to carry that caveat with these findings into future meetings and reports.

Utilization rates measure how much care was delivered – that is, the volume of services. But volume does not inform or indicate other critical measures of care: whether foregone care was clinically appropriate; how did beneficiaries who did not receive care fare, or how many additional hospital days preceded post-acute placement for those who received it. The Commission recognized this in Chapter 4 of its June 2026 Report to the Congress, which observed that lower MA use "may reflect active care management that improves PAC efficiency rather than diminished access to clinically appropriate care," while also cautioning that "reductions in use do not automatically imply improvements in efficiency, and it is essential to ensure that beneficiaries have timely access to medically necessary PAC services."[5] FAH urges the Commission to give equal consideration to both findings as it continues this analysis.

Existing Evidence Raises Important Questions About What Is Driving the Differences

A June 2025 study by NORC at the University of Chicago, using FFS claims and MA encounter data from 2018 through 2022, found that by 2022, patients discharged to an IRF had spent a median of 10 days in the hospital under MA compared with six under FFS. For patients discharged to an LTCH, the figures were 22 days for MA beneficiaries and 13 days for FFS beneficiaries.[6] The Commission's regression analysis found that, after controlling for the hospital, diagnosis-related group, and intended discharge destination, hospital stays for MA beneficiaries in fiscal year 2024 were 4.9 percent longer than FFS stays for patients discharged directly home, but were *32.3 percent longer* for patients discharged to an IRF.[7] Chapter 4 concluded that this pattern "suggests that MA plans, through activities such as prior authorizations, could slow beneficiary discharges to PAC."[8] Longer stays not only require more resources, but also increase patient risk of function decline due to delayed rehabilitation services.

Furthermore, when MA beneficiaries appeal prior authorization denials, a substantial share of the denials for IRF and LTCH care do not withstand clinical and/or legal review and are overturned. In June 2026, the HHS Office of Inspector General (OIG) reported that MA organizations overturned 43 percent of appealed IRF denials and 36 percent of appealed LTCH denials, findings OIG said indicate that some beneficiaries were initially denied medically necessary care.[9]

These early findings alone do not establish whether differences in utilization reflect effective care management, barriers to medically necessary care, or a combination of the two. FAH recognizes that further analysis is needed and encourages the Commission to consider the following questions:

- **What explains the pattern in hospital length of stay by PAC discharge destination?** The difference between number of patient hospital days in MA versus FFS is smallest for patients going home and largest for those going to an IRF or LTCH.

- **What happens to an MA beneficiary whose IRF authorization is denied and never appealed?** MA beneficiaries who are denied entry to an IRF are often redirected to a lower setting of care. Understanding what post-acute care the MA patient ultimately receives, if any, and the associated health outcomes is essential to assessing whether lower post-acute utilization reflects more efficient care or barriers to medically necessary services.

- **Where do beneficiaries wait while an MA appeal is pending, and who bears the cost of those days?** Commissioners raised both questions at the September meeting.[10]

- **To what extent are MA beneficiaries who would qualify for IRF or LTCH care under FFS coverage criteria receiving care in other settings, and does that care meet their clinical and rehabilitation needs?** At the median, MA users of these settings received more days of care over the year than FFS users (15 versus 14 in IRFs and 32 versus 28 in LTCHs), which staff noted may suggest greater medical complexity.[11]

Access to PAC Is Broader Than Prior Authorization

FAH encourages the Commission to examine factors beyond prior authorization that may affect access to post-acute care and may not be fully captured in the available data.

Network participation. As one Commissioner noted in September, MA network adequacy standards apply to SNFs but not to IRFs, which are licensed as hospitals.[12] The same is true of LTCHs.[13] Because these standards do not include IRFs or LTCHs, a plan can meet them without contracting with either. Further analysis could help assess

whether plan networks provide sufficient access to these settings and whether network limitations create barriers to care that are not captured in prior authorization data.

Whether a comparable option exists. Post-acute settings provide different levels of care, and Medicare's coverage rules treat the post-acute settings as distinct. IRF coverage generally requires at least three hours of therapy a day, face-to-face visits by a rehabilitation physician at least three days a week, and frequent interdisciplinary team conferences led by a rehabilitation physician.[14] SNF coverage requires none of these. For MA beneficiaries who meet IRF eligibility criteria, placement in a SNF means receiving a different level and intensity of rehabilitation care, with potential implications for recovery and outcome durability.

Benefit design and plan rules. Staff reported that MA plans' payment arrangements, cost-sharing rules and prior authorization requirements vary, and one Commissioner identified benefit design as a main driver of the difference in SNF length of stay. As another Commissioner noted, Medicare Plan Finder does not show which plans contract with which post-acute providers.[15]

FAH Members' Experience with Post-Acute Placement

Many FAH members operate acute care hospitals that include an inpatient rehabilitation unit. Case managers at these hospitals describe the following sequence.

A patient recovering from a stroke or a complex orthopedic injury is evaluated by the attending physician and the therapy team, who recommend IRF care. For an FFS beneficiary, the transfer is arranged once the patient is medically ready and the hospital verifies the patient meets the Medicare program's eligibility and coverage criteria. For an MA beneficiary, the hospital submits a prior authorization request and waits, sometimes for several days. The MA plan will often not appropriately apply Medicare coverage criteria, and default to SNF or home health, prompting a peer-to-peer review and then an expedited appeal. Throughout, the patient remains in an acute care bed, without the intensive therapy the care team recommended. During that time, the bed is not available to other patients, including those waiting in the emergency department. If the appeal succeeds, the patient is transferred to the IRF after the delay and an increased risk of function decline. If the family chooses not to wait for the MA appeal process, the patient is discharged to a SNF with available clinical capabilities that may not meet the patient's rehabilitation needs. For a ventilator-dependent patient awaiting LTCH placement, the same sequence can stretch over weeks.

In administrative data, this sequence appears as a longer hospital stay followed by either delayed IRF admission or a SNF stay. The Commission's findings that IRF-bound MA patients stay 32 percent longer in the hospital and that MA beneficiaries use IRFs at one-third the FFS rate may reflect the same sequence of events. The cost of those days falls largely on the beneficiary, whose cost sharing can rise, and the hospital, which is generally paid a fixed amount per case that does not grow with the added days.[16] One Commissioner suggested that staff explore avoidable and excess bed days as a form of cost shifting in their hospital interviews,[17] and FAH strongly supports that line of inquiry.

Conclusion

As staff refines their findings and continue their interviews this spring, FAH encourages the Commission to:

- **Combine patient length of stay (LOS) values across both acute and post-acute settings to accurately assess LOS increases.** Days spent waiting for MA prior authorization or placement are part of the system cost and the patient experience, even though they appear in neither program's post-acute spending.

- **Supplement claims and encounter data with information collected directly from hospitals.** Un-appealed denials, time spent waiting and outcomes after a redirected discharge leave little trace in administrative data. A structured survey of hospital case managers and discharge planners could help fill these gaps. The California Hospital Association took a similar approach in 2024, surveying California hospitals on the frequency and causes of discharge delays.[18] Noting these limitations alongside the findings would also help readers interpret them.

- **Give particular attention to IRFs and LTCHs.** These settings show the largest differences in use. Because roughly two-thirds of IRFs are hospital-based units that cannot be separated from their host hospitals on the cost report, the Commission's June analysis of IRF finances was necessarily descriptive.[19]

- **Incorporate educational resources on PAC settings.** Include in future reports educational materials describing the differences among post-acute care settings so that readers can better understand the services each setting provides, the beneficiaries who are eligible for care in each setting, and when these settings may, and may not, serve as clinically comparable alternatives.

FAH members can offer practical insights from both acute and post-acute care settings to inform the Commission's ongoing analysis. Hospital discharge planners and case managers can share their experiences with placement decisions, prior authorization and delays in securing appropriate care. IRF and LTCH leaders can provide additional perspective on patient needs and factors affecting admissions. We welcome the opportunity to facilitate discussions between our members and Commission staff.

If you have questions, please contact Alyssa Keefe, Senior Vice President and Head of Policy, at akeefe@fah.org or (202) 624-1500.

Sincerely,

/s/

Charlene MacDonald
President and Chief Executive Officer

Attachment: NORC at the University of Chicago, Analysis of Hospital Discharges to PAC Settings Among Medicare Beneficiaries (June 2025)

Endnotes

[1] Hong, I., Goodwin, J. S., Reistetter, T. A., Kuo, Y. F., Mallinson, T., Karmarkar, A., Lin, Y. L., and Ottenbacher, K. J. (2019, December). Comparison of functional status improvements among patients with stroke receiving post-acute care in inpatient rehabilitation vs skilled nursing facilities. JAMA Network Open, 2(12), e1916646. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2756256

[2] Medicare Payment Advisory Commission. (2024, June). Report to the Congress: Medicare and the health care delivery system (Chapter 5), comparing IRF cases with comparable SNF cases. https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_Ch5_MedPAC_Report_To_Congress_SEC.pdf

[3] Social Security Act § 1886(m)(6)(A); 42 CFR 412.522(b). LTCH discharges qualify for the standard LTCH payment rate when the patient's preceding acute care hospital stay included at least three days in an intensive care unit or the patient received at least 96 hours of mechanical ventilation in the LTCH.

[4] Medicare Payment Advisory Commission. (2026, September 4). Examining use of post-acute care services by beneficiaries in fee-for-service Medicare and Medicare Advantage [Presentation slides], slides 14 and 28. https://www.medpac.gov/wp-content/uploads/2026/09/Tab-E-PAC-volume-Sept26-FINAL.pdf

[5] Medicare Payment Advisory Commission. (2026, June). Estimated association between Medicare Advantage enrollment and hospitals' and post-acute care providers' finances. In Report to the Congress: Medicare and the health care delivery system (Chapter 4), p. 135. https://www.medpac.gov/wp-content/uploads/2026/06/Jun26_Ch4_MedPAC_Report_To_Congress_SEC.pdf

[6] NORC at the University of Chicago. (2025, June). Analysis of hospital discharges to PAC settings among Medicare beneficiaries. https://strengthenhealthcare.org/wp-content/uploads/2025/06/PAC-Analysis-Findings.pdf

[7] Medicare Payment Advisory Commission (2026, June), pp. 142-143 and Table 4-1.

[8] Medicare Payment Advisory Commission (2026, June), p. 143.

[9] U.S. Department of Health and Human Services, Office of Inspector General. (2026, June). The three largest Medicare Advantage organizations denied requests for long-term acute care and inpatient rehabilitation at some of the highest rates (OEI-09-24-00330). https://oig.hhs.gov/reports/all/2026/the-three-largest-medicare-advantage-organizations-denied-requests-for-long-term-acute-care-and-inpatient-rehabilitation-at-some-of-the-highest-rates/

[10] Medicare Payment Advisory Commission. (2026, September). September 2026 public meeting transcript, session on post-acute care use in fee-for-service Medicare and Medicare Advantage. https://www.medpac.gov/document/september-2026-public-meeting-transcript/

[11] Medicare Payment Advisory Commission (2026, September 4), slide 16; Medicare Payment Advisory Commission (2026, September), public meeting transcript.

[12] Medicare Payment Advisory Commission (2026, September), public meeting transcript.

[13] 42 CFR 422.116(b)(2), which lists the facility types subject to MA network adequacy standards; the list includes skilled nursing facilities but not IRFs or LTCHs.

[14] 42 CFR 412.622(a)(3) through (a)(5).

[15] Medicare Payment Advisory Commission (2026, September), public meeting transcript.

[16] Medicare Payment Advisory Commission (2026, June), pp. 133 and 144.

[17] Medicare Payment Advisory Commission (2026, September), public meeting transcript.

[18] California Hospital Association. (2024, February 6). Survey: Insurance company red tape leaves thousands of patients stranded in CA hospitals every day. https://calhospital.org/survey-insurance-company-red-tape-leaves-thousands-of-patients-stranded-in-ca-hospitals-every-day/

[19] Medicare Payment Advisory Commission (2026, June), pp. 135 and 166.