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STATEMENT
of the
Federation of American Hospitals
to the
U.S. House of Representatives Committee on Ways and Means
Subcommittee on Health
Re: "After the Hospital: Ensuring Access to Quality Post-Acute Care"

March 11, 2025

The Federation of American Hospitals (FAH) submits the following statement for the record in advance of the House Committee on Ways and Means Health Subcommittee hearing entitled "After the Hospital: Ensuring Access to Quality Post-Acute Care."

The FAH is the national representative of over 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services.

The FAH commends the Subcommittee's commitment to promoting access to quality post-acute care. Post-acute care settings have a unique mission to help patients return to "normal life" and regain independence after major accidents, surgeries, or serious illnesses. These specialized facilities provide varying levels of medical treatment, rehabilitation, and therapy to bridge the gap between the patient's acute hospital care and their return home. Their mission is to restore patients' strength, mobility, and overall well-being through personalized treatment plans, cutting-edge technology, and multidisciplinary care teams. Post-acute care services help individuals transition back to their daily lives and back into the workforce, ensuring they receive the support needed to regain their highest level of independence instead of finding themselves back in the hospital.

We look forward to working with Congress and the Administration on ensuring access to quality post-acute care and offer the following comments in support of our shared goal:

Rein in Abuses in Medicare Advantage

The FAH and our members support the Medicare Advantage (MA) program and the way the program can offer private coverage options and flexibility beyond the benefit structure of Traditional Medicare. Today, many of our members serve more seniors with MA coverage than those on fee-for-service. However, we are increasingly concerned by the alarming practices of MA plans that harm patients by eroding access to and affordability of medically necessary care – including post-acute care.

Abusive practices by MA plans include systematic efforts to inappropriately deny, limit, and delay the delivery of health services and care. This activity results in facilities and caregivers diverting precious resources and time to respond to care denials and delay tactics and away from their core mission of patient care.

MA delays and denials through prior authorization and inconsistent administrative processes add tremendous costs to the health care system. Hospitals and physicians must hire teams of clinical and non-clinical staff, and divert resources to costly information systems, to keep up with the prior authorization and payment hurdles that MA plans erect to slow down patient care and payment. These practices also mean that seniors covered by MA do not receive the same access to care as seniors on Traditional Medicare.

To improve access to post-acute care, we urge lawmakers to simplify the administrative barriers MA plans construct by requiring MA plans to ensure that their patients receive the same levels of coverage as patients in Traditional Medicare. We urge the new Administration to track and report prior authorization denials and appeals at the service levels and provide this information to MA enrollees. Doing this will add transparency to the MA prior authorization processes and would allow seniors to be better informed as they work to choose plans that truly cover the health care they need, including post-acute care.

MA Discharge Delays and Network Adequacy

MA beneficiaries routinely experience inappropriate delays in discharge from the hospital to inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and skilled nursing facilities (SNFs). This is due to MA plans lack of adequate post-acute networks and post-acute providers in these networks willing to accept beneficiary discharges, and utilization of review activities that include prior authorization delays when moving a patient to the post-acute setting.

When a patient is ready for transfer from an acute-care setting to a post-acute environment the most appropriate course of action is the prompt and safe transfer of the patient to begin receiving post-acute care (e.g., rehabilitation) in the most suitable environment. MA plans are often financially incentivized to keep beneficiaries in the hospital longer when they pay hospitals using a case rate, such as through the Medicare Severity Diagnosis Related Groups (MS-DRG) system, rather than incurring the additional cost of paying for separate post-acute care services.

MA post-acute networks often do not include an adequate number of post-acute facilities to ensure that the appropriate facility is available and post-acute care is not delayed or disrupted. The FAH

urges Congress to recommend that MA plans be required to demonstrate meaningful network access, including by raising the minimum number of in-network post-acute facilities, establishing a minimum facility-to-beneficiary ratio for in-network IRFs and LTCHs, and monitoring delays in inpatient hospital discharges due to the lack of capacity among in-network post-acute facilities in MA. MA organization's practices should be audited to determine whether they are approving timely discharges to an appropriate post-acute setting. FAH members do not routinely experience these post-acute care discharge issues with their Medicare fee-for-service beneficiary population.

Current network adequacy standards can also fail to capture the realities of post-acute care access as they do not ensure that each MA organization offers a sufficient number of in-network post-acute beds. Minimum bed number requirements, found under 42 C.F.R. § 422.116(e)(2)(iii), can be met with a single in-network skilled nursing facility (SNF) offering little incentive for MA organizations to develop robust post-acute networks. Members of this Committee have asked CMS to ensure that MA plans meet minimum network adequacy requirements for LTCHs and IRFs, separately and in addition to SNFs, and implement measures to ensure timely discharges to appropriate post-acute settings. These steps are essential to address the current gap between theoretical network adequacy and actual access to timely, accessible, high-quality post-acute care and we urge Congress to make these network adequacy changes a requirement.

Finally, we continue to urge Congress and CMS to consider incorporating network adequacy and stability into the Star Ratings Program. A metric reflecting an MA plan's historical performance on network adequacy and stability would provide valuable transparency for enrollees seeking to make informed plan choices and use quality-based competition to incentivize the MA market to meet enrollees' demands for robust and reliable networks.

Reverse Nursing Home Minimum Staffing Requirements

CMS recently set new nursing home staffing standards that mandate a one-size-fits-all staffing model that will exacerbate the nursing workforce crisis, jeopardize access to care, and increase costs for seniors and the Medicare and the Medicaid programs. Mandated ratios impede providers' ability to deliver quality care and undermine the flexibility needed to retain an adequate workforce while meeting the changing care guidelines.

Mandated nurse staffing ratios are an approach that is informed by outdated care models based on the staff roles and responsibilities of the past. Such thresholds are not reflective of the modern care models that consider the dynamic integration of advanced technology and collaborative interprofessional team-based care. These standards prevent facilities from advancing and responding to emerging staffing models that are more effective and safer for patients, nurses and other caregivers. Imposing an approach that impedes innovation in care delivery will inadvertently harm our collective goals to improve quality and maintain a safe and sustainable care workforce. We urge Congress to direct CMS to eliminate nursing home staffing ratios that impede providers' ability to deliver innovative, quality care.

Mitigate LTCH Losses for High Cost and Complex Cases

LTCHs are specialized hospitals that provide extended medical and rehabilitative care to patients with serious, complex, and chronic conditions requiring prolonged hospital-level care. They are a critical part of the post-acute care continuum and are distinct from SNFs and IRFs due to their focus on medically complex patients. LTCHs typically treat patients who need intensive, hospital-level care for an extended period, generally for more than 25 days on average. These hospitals provide services such as prolonged ventilator weaning and respiratory care, comprehensive wound care for non-healing or complex wounds, management of severe infections (e.g., sepsis), specialized rehabilitation for patients recovering from major illnesses, injuries, or surgeries, and intensive medical management.

The Pathway for SGR Reform Act of 2013 included key provisions that reformed Medicare's LTCH Prospective Payment System (LTCH PPS) to create a two-tiered payment system where only certain cases continued to receive full LTCH PPS rates, while others were paid at lower rates equivalent to the general acute inpatient PPS rates. The changes began in 2016 but were not fully phased-in until FY 2020 (with some extensions for COVID-19). The reform significantly shifted LTCH incentives, reinforcing their role as a setting for high-acuity, long-stay patients rather than a post-acute extension of general hospitals.

Under the LTCH PPS, Medicare determines additional payments for high-cost outlier (HCO) cases that have extraordinarily high costs relative to the costs of most discharges. CMS sets a threshold each year at the required losses that a LTCH must incur under this system before a case with unusually high costs will receive the additional outlier payments. In 2018, the HCO fixed loss threshold was $27,381. During the COVID-19 pandemic, the HCO threshold began to inflate dramatically – requiring extensive losses on the most complex and sickest patients. Today, a high-cost patient will not qualify for additional outlier payment until the LTCH loses at least $77,048. With the HCO fixed loss threshold increasing by almost three times the 2018 level, LTCH losses are putting pressure on their ability to take the highest acuity and complex patients that need LTCH care.

We urge Congress and CMS to address this issue and ensure that high-acuity, long-stay Medicare patients can continue to access LTCH services.

Unified PAC PPS

The *Improving Medicare Post-Acute Care Transformation (IMPACT) Act* of 2014 was enacted to generate standardized patient assessment data across the various post-acute settings and provide Congress with the opportunity to consider changes to post-acute payment. CMS has implemented numerous changes and overhauls in each of Medicare's post-acute care payment systems since IMPACT was enacted. As a result, Medicare payments for post-acute care are now driven by patients' clinical conditions and characteristics instead of by, for example, the volume of therapy provided.

These more recent policy changes and payment overhauls address the primary "paying-for-volume" concerns that were present within some post-acute care payment systems when the IMPACT Act was originally considered by Congress. Accordingly, the need to dispense with the existing post-acute payment systems and replace them with a single payment program (the "PAC") no longer

exists and such reforms would be highly disruptive to the entire care continuum. Indeed, since receiving CMS and MedPAC reports about a single unified post-acute care payment system (PAC PPS), Congress has never pursued the idea.

The FAH and its members urge the committee to carefully consider any additional changes to post-acute care and understand the steps that would be required before any future overhaul towards a single post-acute payment system is even contemplated.

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We look forward to working with you on these important matters. If you have any questions or wish to speak further, please do not hesitate to reach out to me at cmacdonald@fah.org.

Sincerely,