Testimony of Paul Dongilli
President and CEO of Madonna Rehabilitation Hospitals
March 11, 2025

Chairman Buchanan, Ranking Member Doggett and Members of the Subcommittee on Health, thank you for the opportunity to participate in today's hearing. My name is Paul Dongilli and I am President and CEO of Madonna Rehabilitation Hospitals. I am here today on behalf of the National Association of Long Term Hospitals (NALTH), and my testimony is also endorsed by the American Medical Rehabilitation Providers Association (AMRPA). NALTH is the only hospital trade association that is devoted exclusively to the needs of medically complex patients who require services provided by long-term acute care hospitals (LTCHs), and correspondingly, AMRPA is the only national trade association that advocates exclusively for inpatient rehabilitation hospitals and units (referred to by policymakers as inpatient rehabilitation facilities, or IRFs). Madonna Rehabilitation Hospital is proud to operate nationally recognized LTCHs, IRFs, as well as an accredited skilled nursing facility. Overseeing three distinct sectors of the post-acute care space makes me uniquely positioned to opine on issues impacting patient access, appropriate and timely post-acute care (PAC) admissions, and payment adequacy. I look forward to speaking with the Committee on these incredibly important issues facing our aging population today.

Madonna has been in existence for 63 years with facilities located in Lincoln and Omaha. Madonna's Lincoln campus LTCH is co-located with our free-standing rehabilitation hospital along with a nursing facility. This arrangement has enabled Madonna to establish a comprehensive post-acute care continuum meeting the needs of individuals with catastrophic injury or illness. Madonna's services are built on a comprehensive clinical program serving patients with traumatic injuries along with neurological, pulmonary, complex medical and wound conditions. Our unique co-location structure and specialized clinical program focus has allowed us to serve patients from across the country; in the last year we have admitted patients from 89 distinct hospitals from 17 different states.

Before I dive into the substance of my testimony, I want to start by telling you a story about a patient. 73-year-old Randy Lamer came to Madonna after spending two weeks at a South Dakota hospital. Randy had been hit by a car while riding his bike and arrived at Madonna requiring a tracheostomy and a ventilator to breathe. He had also sustained a severe brain trauma in the accident and had to wear a helmet following a craniotomy. After three months in our LTCH, Randy was transferred to our IRF. Finally, five months after arriving, Randy walked out of Madonna and returned home to South Dakota with Gloria, his wife of 54 years. I'm telling this story for a couple of reasons: first, it illustrates the different levels of post-acute care offered at Madonna and how patients move between them. Second, we see miraculous recoveries such as this regularly, but without help from Congress, we are worried the intensive services offered at the LTCH level of care in particular will not be available for future patients like Randy when they need it most.

Background on LTCHs, IRFs, & SNFs and the Vital Role Served by Each

LTCHs, IRFs and Skilled Nursing Facilities (SNFs) play an important role in the continuum of health care. Some people who are hospitalized with an injury or illness are not ready to return home upon discharge and require a level of care that can only be provided in an inpatient setting. Those who need to continue convalescing, with limited access to a physician or an advanced nurse, go to SNFs; those who require and can tolerate intensive physical rehabilitation and complex medical management are transferred to IRFs; and those whose are clinically complex with significant medical needs, including continued around-the-clock treatment from an interdisciplinary team of doctors, nurses and other medical professionals, go to LTCHs.

Although these three levels of care are considered "inpatient" they are not all equal levels of inpatient care. The resources available in each level as well as the regulatory requirements differ as mandated by each settings' Conditions of Participation. Although they are imprecisely referred to as "facilities," IRFs are in fact licensed hospitals or units of hospitals. As such, our inpatient rehabilitation hospitals employ the staffing, medical equipment, and other technologies needed to provide significant medical management and oversight of patients' underlying and co-existing conditions, in addition to the rehabilitation therapy services provided in these facilities. Given the complexity and long-term trajectory of medical rehabilitation patients' care and recovery, IRF admission determinations and referrals for post-discharge services (e.g., outpatient therapy, home health services) are determined by patients' treating physicians and their multidisciplinary care teams. This in turn drives IRF patients' strong rates of return to home and community compared to other PAC settings and helps prevent avoidable post-stay complications and readmissions.

LTCHs are acute care hospitals that offer specialized services and access to specially trained staff. These hospitals care for patients with greater medical needs than IRFs and SNFs. LTCH patients require extended acute care reflecting their higher medical complexity and are not yet ready for the intensive rehabilitation therapy offered in IRFs. Going back to the story I just told, when Randy was admitted he was far too sick for rehabilitation services and needed to be in the LTCH. But, as he improved, he was able to move to the next care setting and receive specialized rehabilitative therapies.

To be recognized as an LTCH by Medicare, a hospital must have a greater than 25-day average length of stay for Medicare Fee-for-Service (FFS) beneficiaries that meet certain criteria. Because of their higher complexity, patients spend an average of almost 27 days in an LTCH, while the average length of stay in a regular hospital is 5.2 days.[i] As a result, LTCH patients are often more costly compared to patients treated in other settings.

At Madonna, our Transitional Care Unit (TCU) is a licensed skilled nursing facility. The TCU is a 30-bed unit providing patients with access to Madonna's medical rehabilitation services and nursing care. Patients on the TCU receive therapy to meet individual needs as well as skilled nursing care.

Madonna also operates a long term care facility that provides residents with 24 hour nursing services and access to our rehabilitation professionals.

Madonna Rehabilitation Perspective on Unified Post-Acute Care Payment System & Similar Cross-Sector Reform Efforts

At Madonna we recognize the ongoing need to evaluate Medicare payments and ensure programs are operating in a fiscally responsible way. However, I have strong concerns about recent payment model reform efforts that likely would not reflect the core differences across post-acute settings and the evolving needs of patients – as illustrated by stories such as Randy Lamer's.

There have been coordinated efforts undertaken by relevant entities, including the Centers for Medicare and Medicaid Services (CMS) and the Medicare Payment Advisory Commission's (MedPAC), as required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, to assess the feasibility and impact of adopting a single Medicare payment system across all post-acute care providers, including LTCHs and IRFs. AMRPA, NALTH, and the other post-acute care groups all collectively expressed concern that the prototype under consideration did not fully recognize differences in patients and levels of care across settings.[ii] The organizations raised concerns that implementation of a single payment system across post-acute care settings would be an extremely complex endeavor that would create serious risks for patients cared for at our facilities. CMS and MedPAC seemed to both recognize these concerns, as neither entity proposed an actual unified PAC PPS for implementation, and both noted the significant complexity (and "possibly controversial" outcomes) with such effort.

MedPAC subsequently pursued a "smaller scale" cross-sector PAC reform model for IRFs and SNFs. Similar to the Unified PAC PPS efforts, MedPAC recognized the adverse patient impacts that were likely to stem from such payment reform, and it ultimately did not recommend this type of model in its 2024 Reports to Congress.

It is important to note that, when passed in 2014, one of the IMPACT Act's core goals was to ensure that seniors received the "highest quality and most cost-effective care possible."[iii] At that time, several of the post-acute care payment systems were not optimally structured to achieve these results. However, in the last 10+ years, significant reforms to the SNF, IRF, and home health PPS have resulted in payments that take into the burden of care and the unique needs of each patient. These changes were specifically designed to better match payments with patients' diagnosis, functional level, comorbidities, and other factors – precisely in line with the IMPACT Act's goals.

Given the recognized complexity and difficulty in trying to advance cross-sector reforms, I strongly urge Congress to shift its focus to ensuring each PAC payment system reflects the needs of the patients served and the resources required to care for them. I applaud policymakers for making such changes to three of the four payment systems; however, as I'll detail shortly, significant reforms are still needed to the LTCH PPS. Rather than making further attempts at full-scale PAC reform, I urge Congress to instead assess the key changes made to the SNF and IRF payment systems since the IMPACT Act's adoption and adopt needed reforms in the LTCH system to improve payment accuracy and access to care.

Recent SNF & IRF Payment Reforms Match Payments to Patient Needs While Improving Longer-Term Outcomes

In October 2019, CMS implemented the "Patient Driven Payment Model" (PDPM) for SNFs. The transition from Resource Utilization Groups (RUGs) to PDPM shifted SNF reimbursement from a system which relied heavily on the volume of therapy minutes provided to patients to a more patient-centered approach based on an individual's clinical characteristics and needs. Essentially, providers are now being reimbursed for the complexity of each patient's care rather than the volume of therapy

delivered. PDPM also includes a Variable Per Diem adjustment that adjusts the per diem rate for the course of the stay.

Madonna's experience with PDPM has been largely positive as we have found it better aligns the payment system towards the unique needs of each patient, consistent with the goals of the IMPACT Act.

Similarly, since its implementation in 2002, the IRF PPS has been based upon assigning patients into Case-Mix Groups (CMGs) which differentiate payment by primary diagnosis, functional status, and tiered comorbidities. Because the IRF PPS CMGs are based upon the patient's clinical characteristics and not on the services provided to the patient, they have been used as a model for recent payment system updates, such as the SNF PDPM and the Home Health Agency (HHS) Patient-Driven Groupings Model (PDGM). In 2019, CMS made a significant change to the IRF PPS in which it removed the use of the FIM Instrument and moved to the use of new case-mix groups that utilize standardized patient assessment data elements (SPADEs), which were included in the assessments for all post-acute care settings. Annual adjustments are also made to the tiered comorbid condition lists and payment weights and average LOS values to make sure the IRF PPS is providing payment consistent with the costs of caring for complex patient populations. These payment changes, collectively, have made the IRF, SNF and HHA payment systems better able to differentiate payment based on patient need across settings, essentially achieving the goals of the IMPACT Act without the disruption and likely adverse clinical impacts of a move to a unified PAC PPS.

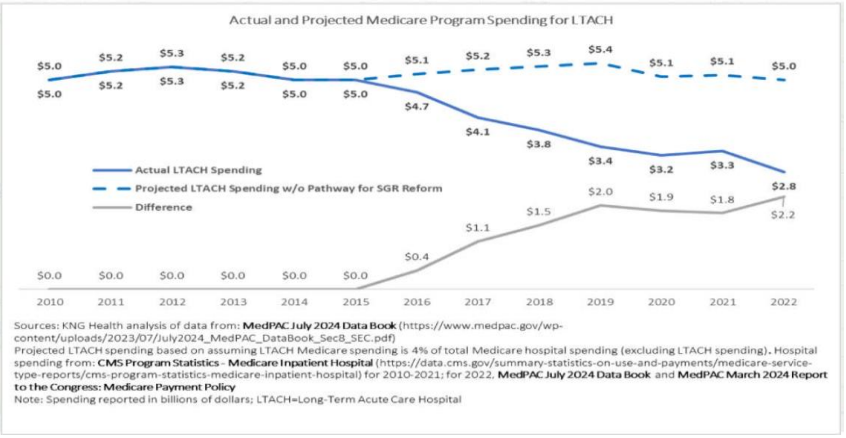
Need for LTCH Payment Policy Reform

Despite these major changes in the other PAC payment systems, Medicare LTCH payment policy has, unfortunately, not evolved to match the increasing complexity of patients cared for in these specialty hospitals. The LTCH payment system, which is based on DRGs similar to the IPPS, does not adequately refine or adjust payment to account for high resource comorbid condition treatments like mechanical ventilation and dialysis. Instead, payment reform has centered on payment criteria.

Medicare Payment Policy Changes

<u>Site Neutral Payment Rates</u>

The Cumulative Hit to LTCHs from the Dual Payment System between 2016 and 2022 was $11 Billion, and will Continue to Grow



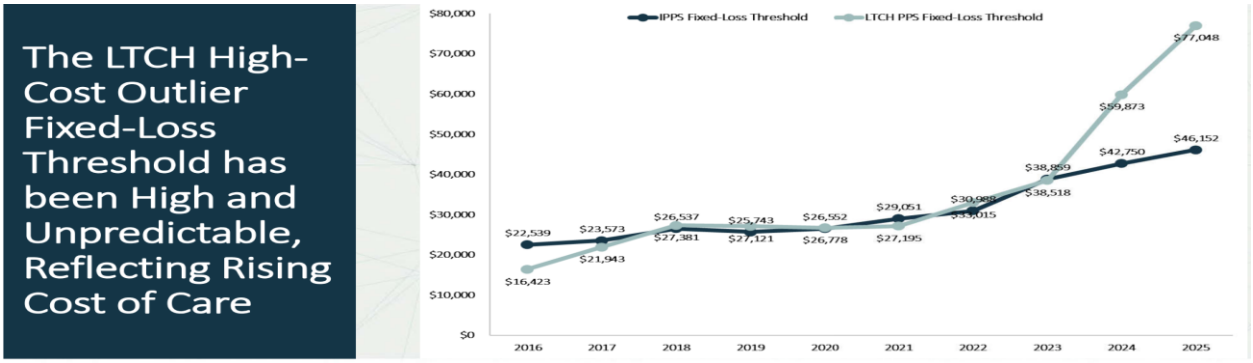
The introduction of the dual-payment system for LTCHs, starting in 2016, shifted the Medicare patient mix at these hospitals towards higher acuity patients. Under the system, Medicare pays rates established under the LTCH Prospective Payment System (PPS) for patients meeting payment criteria (i.e. patients with 3 or more days in an ICU during the STACH stay immediately preceding LTCH admission or on

prolonged mechanical ventilation at an LTCH). For cases not meeting criteria, Medicare pays LTCHs a "site-neutral" amount, which is comparable but less than what a STACH would receive for the same patient, as determined under the hospital Inpatient PPS.

NALTH supports the intent of this payment system – LTCHs should focus on treating the sickest patients. However, we have two key concerns. First, the payment criteria are proxies for patient complexity. As a result, some patients who need and could benefit from the type of care provided in an LTCH will not meet payment criteria. Because site-neutral payments are roughly 40 percent of payments paid under the LTCH PPS, LTCHs face financial ruin from accepting too many of these cases. Second, the reduced volume and shift to higher complexity cases increased costs for LTCHs, but Medicare payments did not adjust accordingly.

A result of this new payment system is that LTCHs are no longer able to provide care to many critically ill patients who would benefit from that care. Additionally, between 2016 and 2022, Medicare FFS spending on LTCH care decreased by a cumulative $11 billion due to this dual payment system, falling from $4.7 to $2.8 billion in annual spending. The reduction in Medicare spending for LTCH care likely exceeded Congress' expectation and resulted in savings to the Medicare program far in excess of the original Congressional Budget Office (CBO) score of $3.1 billion over 10 years.

<u>High Cost Outlier Threshold</u>
Another Medicare FFS policy that has been putting significant financial strain on LTCHs like Madonna is the High Cost Outlier Fixed Loss Amount Threshold.



By way of background, under the LTCH payment system, LTCHs are eligible for high cost outlier (HCO) payments to reduce financial losses associated with extremely high-cost standard rate cases. **Over the last two years - since 2023 - the HCO fixed-loss threshold has more than *doubled* and increased from $38,518 to $77,045 for FY 2025.** In other words, the amount of money a hospital must *lose* on a case before they are eligible for an additional payment has doubled over only 2 years. Absent Congressional action, future first-loss outlier thresholds are likely to continue to increase.

Patient complexity is a key driver of HCOs. Patients admitted to LTCHs tend to be highly concentrated in a small number of condition categories, reflecting these specialty hospitals' focus on critically ill and medically complex patients. A study found significantly higher likelihood of a case being an HCO if they were on prolonged mechanical ventilation.

LTCHs such as Madonna that admit a large share of high acuity patients in any given year are likely to see a high share of high acuity patients in subsequent years. The characteristics of LTCHs and the

patients they serve make it difficult to offset losses on high-cost cases. So, in other words it's a double whammy: hospitals like Madonna, who care for the sickest and most critically ill patients, are underpaid. And then, they now must lose $77,045 before being eligible for an additional payment.

We believe it is Congress' intent that LTCHs treat the sickest of the sick. However, if the HCO is not addressed, LTCHs will be perversely incentivized to try to avoid these patients. While all LTCHs might face significant financial hardship, independent, small and rural facilities particularly cannot take the risk of losing over $70,000 on one patient – a loss or two such as that could be potentially financially devastating. Without Congressional intervention, access to LTCH care for the most critically ill and medically complex Medicare beneficiaries may be impacted.

LTCH Financial Challenges

Unfortunately, despite the important role LTCHs play in the care of critically ill patients, access to LTCH-level of care is on a downward trajectory. The factors I just described threaten LTCHs' ability to continue to serve their communities.

Medicare margins are significantly lower for LTCHs than other post-acute care providers. Between 2017 and 2022, aggregate LTCH Medicare margins ranged from -2.6% (2017) to 6.2% (2021). By comparison, Medicare margins for other post-acute providers ranged from 10.9% (2018 for SNFs) to 24.9% (2021 for home health agencies (HHAs).

While Medicare margins for LTCHs and other providers increased in 2020 and 2021, margins have since returned to their pre-pandemic levels. LTCH operating margins decreased to -3.4% in 2023. The margins are projected to continue to remain negative and fall even further due to continued higher costs and full implementation of the payment reductions under the dual payment system.

LTCH Closures

From 2012 to 2021, the number of LTCHs and LTCH beds decreased by 22% and 24%, respectively, while the Medicare-aged population grew by 29% during this same period. [iv] The bulk of LTCH closures occurred between FY 2017 and FY 2019, when the Centers for Medicare and Medicaid Services (CMS) began phasing-in a new payment system for LTCHs, as required by Congress,

Since 2021, an additional 20 LTCHs closed with only 7 opening, with the number of LTCHs falling from 438 in 2015 to 341 by July 2024. Alarmingly, we understand an additional 17 LTCHs closed in 2024 or announced they would close in 2025. **In other words, about a quarter of our already small industry is gone, leaving patients and families with fewer care options and leaving short term acute care hospitals with fewer available ICU beds.**

Rural LTCH Closures

Between 2018 and 2022, one in five LTCH patients came from rural communities and nearly half (46%) of these rural Medicare patients received care in an LTCH located in a rural or small metropolitan community. Since the dual payment system was implemented in 2016, LTCHs in rural communities were more likely to close than those in larger communities. The impact of such closures on patients and their families is real with a study finding that 91% of Medicare patients treated in LTCHs and living in rural areas had to travel across county or state lines to obtain care.

Currently there are fewer than 350 LTCHs in the nation. Although not in every market, these LTCHs serve both small and large communities, but tend to be located in areas where there is sufficient volume of the most complex cases. Although LTCHs provide acute care, these specialty hospitals are often considered "post-acute care," because roughly 90 percent of admissions to an LTCH follow a hospital inpatient stay in a short-term acute care hospital (STACH). Less than 1 percent of hospitalized Medicare beneficiaries are discharged to an LTCH. In 2023, LTCHs treated about 60,000 Medicare FFS beneficiaries and accounted for less than 5% of all post-acute care (PAC) spending in FFS.

Transferring a patient out of an ICU and to an LTCH increases the short term acute care hospital's capacity to care for more acutely ill patients in need of care. Hospital ICU beds are limited and often in overflow status. Just as important, this transfer provides better patient care. First, research has documented poorer outcomes at capacity-strained hospitals, particularly for severely ill patients. Additionally, discharging patients to LTCHs earlier, for example, may benefit patients by improving the chance that they are able to breath on their own after being on a ventilator. A 2021 study in BMC Pulmonary Medicine finding that **delaying transfer of mechanically ventilated patients to an LTCH decreases the patient's likelihood of successfully weaning.** Another study using 2016 – 2019 Medicare data to estimate the effects of LTCH use on STACH length of stay and ICU days and found that, "patients discharged to non-LTCH settings… spent 7.0 more days in the [short-term hospital] and had 2.2 more ICU days compared to similar patients who were discharged to an LTACH." Impacts were larger for patients on prolonged mechanical ventilation. Nationally, the study estimated that LTCHs **freed up 3.7 million hospital days and almost 700,000 ICU days over the study period.**

It is essential that policymakers recognize core differences across PAC settings and how each type of provider will be deemed appropriate for patients based on their medical management and rehabilitation needs. Policies that stem from notions of interchangeability or try to place patients based on overly generalizable traits (i.e., primary condition) will adversely impact patient care and, most importantly, drive up costs through worse longer-term functional recoveries.

Medicare Advantage Plans Are Limiting Patient Access to Post Acute Care

As Medicare Advantage (MA) market share has grown, prior authorization and denial practices by some plans have been increasingly detrimental to patient access to care across post-acute health care settings. Between 2007 and 2024, the number of Medicare beneficiaries in MA has increased from 19% to 54%. This trend is expected to continue with CBO projecting that MA enrollments will account for 64% of the eligible Medicare population by 2034. [v]

With an analysis finding that rates of discharge to both IRFs and LTCHs are approximately 40 percent lower in MA than in FFS Medicare, this trend presents a significant challenge for Madonna. Many MA plans deny nearly one-half of the prior authorization requests for LTCH admission and inappropriately cite CMS rules or Commercial Clinical Guidelines. The same issues are reported on our IRF side, with a recent AMRPA member survey affirming that approximately 57% of IRF prior authorization admissions are denied. This high rate of initial prior authorization denials triggers a resource-intensive and physician-dependent appeals process, which further delays MA enrollees from transferring to the next appropriate care setting. The resources expended by physicians and hospitals to respond to seemingly rote MA plan denials is draining. Worse yet, as I mentioned earlier, **delaying transfer of mechanically ventilated patients to an LTCH decreases the patient's likelihood of successfully weaning.** For patients in need of IRF care, these delays directly and significantly impact total functional recovery and produce avoidable (and costly) complications.

The low use of LTCHs in MA is largely a result of the use of prior authorization. A NALTH survey found that MA plans only approved 42% of cases for LTCH admission on initial request and 54% of prior authorization requests after appeal of the initial denial. On average, MA plans took over 2 days to approve initial requests and almost 3 days to reach an initial denial. The same AMRPA member survey specifically found that, over a two-month period, MA plan behavior resulted in a total of at least 70,000 acute hospital days waiting for determinations from an MA plan for referrals to approximately 350 IRFs. These delays not only create incredibly taxing situations for patients and their families, but result in massive care transition issues and referral pressures across the entire care continuum.

One part of the appeals process that is particularly troubling for Madonna and other post-acute care providers is the Independent Review Entity (IRE). Maximus is CMS' contactor and serves as a Qualified Independent Contractor (QIC) for denials going through the appeals process. NALTH's policy team examined the IRE decision database and found that between 2020 and 2024, **the IRE overturned less than 1% of LTCH prior authorization denials by MA plans and only 1.5% of IRF denials by MA plans**. In nearly all LTCH cases, the IRE's physician reviewer stated that "the patient could get all services needed at the short-term hospital (STACH)", overruling the treating physician's judgement that the patient should be cared for at an LTCH. On the IRF side, the primary denial reason was the patient's needs "could be met a lower level of care," which CMS has previously identified as an unacceptable rationale for IRF denials.[vi]

By limiting access to medically necessary post-acute care, MA plans eliminate the primacy of the physician-patient relationship in making healthcare decisions for MA enrollees. We are not advocating for eliminating MA, but we are advocating for a level playing field. One of my NALTH colleagues has said that he could possibly eliminate four back-office positions if all of the MA plans were consistent in their admission criteria.

Madonna Rehabilitation Policy Recommendations

NALTH is grateful to Congresswoman Miller, Congressman Hern and Congressman Boyle for the introduction of legislation intended to provide relief and stability to this industry. Additionally, we appreciate the work of your staffs in developing draft legislation that we hope the Committee will consider in short order that would reflect the critical policies included in the Miller and Hern bills.

Specifically, to address the issues I just outlined, NALTH hopes the Committee will quickly move to consider legislation to:

- **Reform the method for determining the HCO fixed loss threshold**; such a change is critical to 1) providing stability after the recent year-over-year increases and 2) reducing the fixed loss amount so LTCHs are not disincentivized from caring for the sickest of the sick
- **Increase access to LTCH care for high-acuity patients by:**
    - **Expanding standard rate criteria to ensure access to care for high acuity patients**; expanding the criteria to include high-acuity patients who do not currently meet the standard rate criteria would potentially free up scarce capacity in short term acute care hospitals by eliminating the need for LTCH-appropriate patients to stay in the ICU for three days and make it possible for more LTCH-appropriate patients to receive such services
    - **Fully reimbursing LTCHs for the cost of caring for high-acuity patients transferred directly from a critical access hospital (CAH)**; we believe this is a commonsense

provision to eliminate red tape and reduce barriers that make it difficult for a CAH to transfer a patient directly to an LTCH; today, for an LTCH to receive a full standard rate payment, the patient must first be transferred to a STACH and then to the LTCH

- **Congress should urge CMS to continue to refine the post-acute care payment systems to ensure the payments reflect the uniqueness of each setting, the case complexity and associated higher resource use**

With regard to Medicare Advantage, NALTH and AMPRA make the following recommendations:

- There must also be clear and consistent enforcement by CMS to uphold existing Medicare Advantage rules and regulations
- We urge greater Congressional oversight, particularly as to how plan behavior is reviewed by an entity that is designed to function in an "independent" manner

These provisions are vital to addressing the issues I have described today that are resulting in LTCH closures and bed reductions and limiting patient access to this level of care.

Importantly, while we understand and appreciate the need for fiscal responsibility, we ask that such legislation is not offset by any reductions to payments for currently qualifying standard rate cases. There is simply no juice to squeeze after an $1l billion reduction in Medicare spending on LTCHs since 2016.

The provisions I just described are critical to ensuring critically ill patients, and particularly patients in rural areas, continue to have access to long-term acute-level care by preventing additional bed reductions and hospital closures. As noted by the American Hospital Association, if LTCHs continue to close and reduce beds, "this will have ripple effects across the care continuum, placing additional burdens on short-term acute care hospitals and their ICUs, which may no longer be able to partner with LTCHs for the care of this unique population due to financial challenges or closures."

Last summer, we as an industry sent a letter to the Committee respectfully asking for consideration of legislation to provide LTCH relief. Last month, we sent a similar letter again expressing the urgency of the situation. The February letter noted 5 hospitals that had signed the previous iteration that had or are about to close. I want to convey the urgency many of my LTCH friends and colleagues and I are feeling as we watch our industry get smaller before our eyes. Absent swift Congressional action, we expect these closures in the industry to continue and for patient access to get increasingly limited.

In addition to these LTCH-specific asks, I also urge Congress to protect payment adequacy for IRFs given the critical role they play in the post-acute care continuum, particularly in the face of an aging population. Furthermore, I reiterate the importance of close Congressional scrutiny of cross-sector reform efforts**,** as many are rooted in inaccurate assumptions that post-acute care settings provide "interchangeable" types of care. Madonna's experience in nearly every sector of the PAC continuum gives me a direct perspective on how such models will result in inappropriate referrals and adversely impact long-term outcomes.

Lastly, there must also be clear and consistent enforcement by CMS to uphold existing rules and regulations in Medicare Advantage to ensure appropriate patient access and timely PAC referrals are not jeopardized as this program grows.

Thank you again for the opportunity to speak here today. On behalf of the patients and families we serve, we are committed to ensuring that chronically critically ill and medically complex Medicare beneficiaries have access to the effective, medically necessary specialized services that Madonna's LTCH, IRF and SNF offer.

I am pleased to answer your questions.

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[i] Sources: CMS FY2019 (September 2022) Cost Reports & CMS Provider Names File (February 2022).

[ii] See. e.g., 2-21 Stakeholder Joint Response to RTI on the Unified Post-Acute Care Payment Prototype; available: https://amrpa.org/wp-content/uploads/2024/09/Stakeholder-Joint-Response-to-RTI-9.14.2021_Final.pdf

[ii] MedPAC June 2023 Report to Congress (pg. 418); https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf

[iii] Ways and Means Committee Press Release: Senate Approves Bipartisan, Bicameral Legislation to Improve Post-Acute Care for Medicare Beneficiaries; available here: https://democrats-waysandmeans.house.gov/media-center/press-releases/senate-approves-bipartisan-bicameral-legislation-improve-post-acute-care

[iv] Lane Koenig, Julia Sheriff, and Elizabeth Hamlett, Patients Face Reduced Access to Long-Term Care Hospitals Due to Closures and Bed Reductions (Long-Term Care Hospital Roundtable, December 2022), accessed at: https://cdn.ymaws.com/nalth.site-ym.com/resource/resmgr/members/congressionalcontacts/itch_roundtable/ltch_roundtable,_ltch_closur.pdf

[v] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/

[vi] 2024 AMRPA Member Survey on Prior Authorization & Related Practices; available: https://amrpa.org/wp-content/uploads/2025/03/2024-Prior-Auth-Survey-Full-Results_FINAL.pdf