Testimony for the Record

Submitted to the
U.S. House Ways & Means Committee
Subcommittee on Health
For the Hearing

"After the Hospital: Ensuring Access to Quality Post-Acute Care"
March 11, 2025
LeadingAge

Chairman Smith, Health Subcommittee Chairman Buchanan, Ranking Member Neal, Health Subcommittee Ranking Member Doggett, and members of the Committee, LeadingAge is grateful for the opportunity to submit this written testimony in response to your March 11 hearing, "After the Hospital: Ensuring Access to Quality Post-Acute Care." We appreciate the attention you are giving to identifying barriers Medicare beneficiaries face in accessing quality post-acute care (PAC).

LeadingAge represents more than 5,400 nonprofit aging services providers and other mission-driven organizations serving older adults that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, community-based services, hospice, and home-based care.

Beneficiary access to PAC services is jeopardized when provider payments don't cover their costs, Medicare Advantage (MA) plans do not process prior authorizations timely or in compliance with Medicare regulations, and well-intentioned or outdated regulations create unnecessary roadblocks to care. Our comments reflect the challenges faced by our skilled nursing facilities (SNFs) and home health agencies (HHAs) over the past decade as payment sources and levels have evolved and administrative burden has increased, both directly impacting current and future access.

Access to PAC Services is Inextricably Linked to Provider Revenue

SNFs and HHAs are being squeezed by declining revenues (total all payer margins), rising costs, the administrative burden -- utilization management and claims adjudication -- of participating in multiple MA plans that now serve more than 50% of Medicare beneficiaries, and regulatory compliance. Each of these factors are chipping away at their financial viability and in turn, beneficiary access to not only the PAC services but also all other services these providers deliver in their communities.

Provider reimbursement is inextricably linked to beneficiary access to care. Providers accept beneficiaries supported by a variety of payment sources (e.g., Medicare, MA, Medicaid, Veterans' Affairs). Reimbursement reductions from any one source jeopardize a provider's ability to cover their costs. Some payers have never fully covered provider costs leaving providers to make up the difference through other payers or by making difficult decisions to reduce their services or sometimes close.

MA Payments to Providers

For decades, traditional Medicare has helped fill gaps left by inadequate Medicaid payments, but as MA enrollment has grown to over 50%, MA provider payments have dropped to 50-80% of traditional Medicare rates, making it difficult for SNFs and HHAs to close the Medicaid funding gap. With limited reimbursement, providers face tough decisions like cutting staff wages, reducing admissions, or even closing, impacting healthcare access and the ability to innovate. MA plans are also reducing service days, increasing administrative burdens, and forcing providers into financially inadequate contracts.

The situation becomes more dire for SNF and HHA providers when the MA enrollment in a market is concentrated in one or two plans and/or exceeds 60-80% of all Medicare beneficiaries enrolled in MA as providers often have little negotiating power and are forced to accept low payments or face financial ruin. According to the 2025 MedPAC Report to Congress: Medicare Payment Policy, "*One study of payments and costs from 2017 through 2019 found that as MA penetration in a county increased, the average total margin of SNFs in the county decreased (Marr and Shen 2024).*"

Some SNFs report being offered MA contracts that pay a single flat rate to provide all levels of patient care or Medicaid rates to provide more complex Medicare SNF care, disincentivizing complex care acceptance. Similarly, low MA rates for home health have led to HHAs refusing MA referrals. These underpayments contribute to hospital backups. We ask Congress to direct CMS to monitor and report MA plan market concentration and identify solutions to protect providers and beneficiaries from the potential consequences that result.

Without Congressional action, CMS's hands are tied. Section 1854 (6)(B)(iii) of the Social Security Act prohibits CMS from intervening in provider-plan contractual arrangements, including setting a provider rate floor to ensure payment adequacy and beneficiaries access to care or requiring MA plans to meet certain quality criteria for providers in their networks.

Once services have been authorized and provided, the next challenge for providers is getting the claims processed and paid for services already provided. MA plans deny claims for previously authorized services, audit claims years after the fact and claw back funds often claiming lack of documentation, and don't pay in a timely way. All of these tactics appear designed to have providers abandon a claim and sometimes they do because they don't have the resources to fight. Premier Inc. reports in its survey of hospitals, health systems and PAC providers, that claims adjudication – this is the process that follows an initial payment denial -- costs these providers more than $25.7 billion in 2023. It also noted that 70% of these payment denials are ultimately overturned and paid resulting in $18 billion of unnecessary expenditures.

The Office of the Inspector General (OIG) has recommended that CMS take steps to clarify MA plans' responsibility related to appropriate clinical criteria, update its audit protocols to address denials and appeals and direct MA plans to take steps to correct their payment processing errors. We encourage Congress to instruct CMS to implement the OIG recommendations and to standardize routine processes in MA such as prior authorizations, claims processing and place reasonable limits on the number of claims that can be audited when a provider is in compliance with the rules.

We ask Congress to enact legislation to establish a process to ensure provider payment adequacy in the MA program. We believe this might be achieved by building up the ***Encounter Data Enhancement Act*** from the 118th Congress (S. 3307) to: 1) collect the necessary encounter claims data to analyze provider

payment types and adequacy, 2) incentivize MA plans to report enhanced encounter claims data accurately and completely, and 3) instruct MedPAC to analyze the collected data and report on provider payment adequacy, the quality of care provided, and the comparative value delivered through the MA and Medicare fee-for-service (FFS) programs.

Medicaid's role in PAC Access

As noted in the 2025 MedPAC Report to Congress: Medicare Payment Policy , Medicare FFS covers 8% of SNF days and makes up about 14% of nursing home revenue, while Medicaid pays for 63% of nursing facility days and more than half of all community-based services for older adults and other eligible populations. States are required to provide nursing home care for all eligible individuals under the Medicaid program and ensure access to enough nursing home providers to meet the demand. Further, states cannot restrict access due to enrollment caps or budgetary constraints. States set Medicaid provider rates, subject to state budget constraints and the will of elected officials. Most state Medicaid rates for nursing homes and home health remain woefully below the cost of providing care.

LeadingAge is concerned that current Medicaid proposals under consideration to decrease the federal government's financial participation, including per capita caps, Federal Medical Assistance Percentage (FMAP) changes, work requirements, changes to provider and managed care taxes, will ripple across the economy.

Any of the proposed Medicaid changes will shift costs to states forcing them to restructure their programs, which we believe will reduce older adults' access to care. States may be forced to no longer fund desired home and community-based services in order to fund required nursing home care. Medicaid cuts to nursing home and home health provider rates or services will compound the losses from MA. Providers who are unable to backfill these losses will close, eliminating stable employment opportunities in their communities. In many rural areas, the exit of the nursing home will reduce access to not only Medicaid long-term services and supports (LTSS) but also eliminate critical Medicare PAC services such as therapies or aide services in their community. Further, limiting access to Medicaid services could shift the costs to Medicare, due to increased hospitalizations.

MA Prior Authorizations Limit PAC Access and Drive Up Provider Cost and Administrative Burden

Most PAC services require prior authorization. Our SNF and HHA members witness daily MA plan denials for care that would be covered under traditional Medicare. Beneficiaries and their families are often reluctant to appeal but there is increasing evidence that appeals are successful. Nonetheless, the appeals process needs to be simplified, shortened and permit engagement from provider advocates to ensure more real-time access to medically necessary care.

LeadingAge and its members have been raising the alarms on MA plan utilization management practices and other issues that threaten Medicare beneficiaries' access to PAC services for several years. Unfortunately, recent regulatory clarifications and limits on prior authorizations in 2024 do not appear to have changed MA plan practices. Our SNFs and HHAs report inappropriate denials, delays, reduced services and incomplete care are on the rise among some MA plans. We've included links to two key reports that underscore how MA prior authorizations continue to increase each year and alarmingly show how plans are denying prior authorizations for PAC services at 3x the rate of all other services.

In addition to limiting access to PAC, MA plans' utilization management practices place considerable administrative burden and costs onto providers because these practices are time-intensive and lack any uniformity. Therefore, providers must navigate each MA plan's unique processes, procedures, codes, portals and policies. This requires them to hire additional highly qualified staff (e.g. RNs, physicians).

Prior authorizations delay care. They require providers to compile and submit reams of documentation (often 40-50 pages per request), in different formats, composition, and methods for the various MA plans. Plans take 1-30 days to review this information and extends further when requests are made over weekends and holidays because many plans don't staff their prior authorization processes seven days a week even though care is still needed. If coverage is denied, the appeals process adds additional waiting time. The impact is that the MA enrollee is hospitalized for a longer time before initiating skilled care, rehabilitation services, or home health care. If a PAC provider accepts the patient while authorization is pending, the provider must issue a Notice of Medicare Non-Coverage to the beneficiary because it is unknown whether the service will be covered by the plan. This puts both the provider and the beneficiary in financial jeopardy if service isn't ultimately authorized by the plan.

When approvals are granted, they are often for only a short duration (e.g., two HH visits or five to seven SNF days) and the provider must again submit reams of documentation to receive authorization to continue needed services (concurrent review). When these are approved, it is often for only a few days at a time or an additional one to two HH visits. There is no standardization across forms, information required, formats, or means of transmission among plans. LeadingAge SNF and HH providers are increasingly seeing denials for needed PAC services ordered by physicians discharging patients from the hospital—services that would be provided under Medicare FFS. Prior authorization processes place significant ethical and administrative burdens on providers, and stresses and costs on beneficiaries.

LeadingAge has been working exhaustively with CMS, Congress and in coalition with other provider groups to improve prior authorization processes and reduce provider administrative burden. LeadingAge has supported the bipartisan legislation of the 118th Congress, ***Improving Seniors' Timely Access to Care Act*** *(S.4532/ H.R.8702)* introduced by Senator Roger Marshall*.* We look forward to working with Senator Marshall and the many other sponsors on this Committee to see this or similar legislation reintroduced and passed by the 119th Congress to standardize and modernize prior authorizations and, track prior authorizations and their outcomes to ensure MA plans are not using this tool as a barrier to PAC.

Given the page limitation requirements for this testimony, please see our other comments to other policymakers on current prior authorization issues and recommendations for improvements.

- LeadingAge Statement for the Record to the Senate Homeland Security & Government Affairs Permanent Subcommittee on Investigations on MA prior authorization denials and delays:
- LeadingAge Response to CMS RFI on MA
- LeadingAge comments to the 2024 CMS MA Data RFI.
- LeadingAge suggestions to CMS on their data collection initiative related to Service Level Data Collection for Initial Determinations and Appeals (CMS-10905) including tracking concurrent review requests (re-authorization or requests to continue care).

Additional reports:

- "Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-acute Care" report (October 17, 2024)
- "Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023"

Nursing Home Minimum Staffing Rule
CMS issued a final minimum staffing rule for nursing homes, "Medicare and Medicaid Programs; Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting" (CMS-3442-F, in April 2024, which became effective June 21, 2024). Its requirements are simply unrealistic given current workforce shortages and funding inadequacies that exist in the health and long-term care system. This is particularly true for rural and underserved areas.

CMS's own estimates indicate more than 79% of nursing homes will be required to hire additional registered nurses (RNs) and certified nursing assistants (CNAs) to comply with the rule at an estimated cost of more than $43 billion to nursing homes. CNAs, who are the backbone of aging services, are in short supply and the Health Resources and Services Administration (HRSA) projects a shortage of more than 350,000 RNs in 2026 alone. Such unrealistic regulations, even with the best intentions, just can't change the math.

Existing workforce shortages already result in backlogs at acute care hospitals, which are unable to discharge patients due to reduced capacity in PAC and long-term care facilities. Home care and hospice providers – already navigating their own workforce challenges – will be short even more workers if they move to nursing homes. Shuffling the relatively small number of direct care workers available between settings will not solve the problem. Furthermore, holding nursing homes to a standard that is impossible to meet and then penalizing them for not meeting that standard will threaten quality, not improve it.

Federal action on minimum staffing standards must be realistic to achieve its intended effect and should be preceded by serious workforce investments to attract, incentivize, and train registered nurses and nurse aides that are currently in short supply. Without staff, there is no care. Shortages force providers to make difficult choices, including limiting admissions, taking beds offline, or, worse yet, closing wings or even ceasing operations.

We need real, comprehensive solutions to address these longstanding workforce issues in aging services. Until there are enough qualified applicants and adequate funding to address these staffing shortages, we urge you to stop implementation of the final minimum staffing rule by passing the ***Protecting Rural Seniors' Access to Care Act*** (H.R. 1683 / S. 750 introduced by Representative Michelle Fischbach and Senators Deb Fischer and James Lankford. This legislation would prohibit the Secretary of Health and Human Services from implementing, administering, or enforcing the provisions of the final minimum staffing rule. Instead, it would establish a nursing home workforce advisory panel to analyze and make recommendations to fix workforce shortages.

Certified Nursing Assistant Training Lockout
CNAs are vital to nursing homes' day-to-day operations, and the new federal nursing home minimum staffing rule will require facilities to significantly increase their CNA staff. In fact, we estimate that to meet these federal requirements, nursing homes will need to hire over 78,000 additional full-time CNAs.

Regrettably, for nearly 40 years, current policy has required nursing homes that are fined above a specific monetary threshold automatically lose their authority to train CNAs for a full two years, regardless of whether the fine was related to the quality of resident care. In many cases, fines result from factors outside the facility's control, yet this CNA training suspension can further exacerbate staffing challenges not only for their nursing home but often also for the broader community.

LeadingAge worked with Representatives Ron Estes and Gerald Connolly and Senators Mark Warner and Tim Scott during the 118th Congress on the introduction and advancement of the ***Ensuring Seniors' Access to Quality Care Act*** (H.R. 8244, H.R. 3227, and S. 1749.) This legislation would address this antiquated provision in law by allowing nursing homes that have resolved their compliance issues to continue their CNA training programs as long as their penalties are not related to resident quality of care. The House Ways and Means Committee passed H.R. 8244 on May 8, 2024, while the House Energy and Commerce Committee passed an identical companion measure (H.R. 3227) on September 18, 2024.

The bill would help secure and maintain a robust pipeline of trained CNAs who are essential to our nation's 1.2 million nursing home residents. As the population of Americans over 65 grows, so too will the need for trained CNAs. We look forward to working with the bill's champions and Committee leaders to reintroduce and pass it in the 119th Congress.

Observation Stays and the 3-Day Inpatient Hospital Stay Requirement to Qualify for SNF

Current Medicare policy requires a beneficiary to have an "inpatient" hospital stay of at least three days in order for Medicare to cover post-hospitalization skilled nursing facility (SNF) care. Patients who receive hospital care under "observation status" or an "observation stay" do not qualify for this benefit, even if their hospital stay lasts longer than three days.

Patients in observation status may spend multiple days in the hospital receiving medical care, tests, treatments, medications, and meals—just like inpatients. However, despite the similarity in care, Medicare does not cover SNF care for these patients after discharge. This can be very confusing for beneficiaries. They are left responsible for the full cost of their SNF stay, creating an unfair financial burden through no fault of their own. The Office of Inspector General (OIG) acknowledges that the 3-day stay rule leads to inconsistent coverage for Medicare beneficiaries and consistently ranks changing this policy among its Top 25 Unimplemented Recommendations.

LeadingAge has worked with Representatives Joe Courtney, Glenn Thompson, Susan DelBene, and Ron Estes to address this issue through the ***Improving Access to Medicare Coverage Act***, which would count hospital outpatient observation stays toward the three-day qualifying hospital stay requirement. If enacted, Medicare patients who spend three days in a hospital, regardless of inpatient or observation designation, can access post-acute SNF care under Medicare. We look forward to continuing our collaboration with our Congressional partners on the bill's reintroduction and advancement in the 119th Congress.

Home Health Cuts Threaten Access to These Services

Medicare home health is a critical benefit that allows for Medicare beneficiaries to rehabilitate at home. It also allows for beneficiaries to remain at home and maintain function. When asked, 95% of Americans say that they prefer to age in place[1] and home health is the only Medicare benefit that is accessible to any medically qualified beneficiary that helps to achieve this goal. Since the implementation of the Patient Driven Groupings Model (PDGM) in 2020, Medicare home health agencies (HHAs) have experienced a nearly 10% cut in fee-for-service (FFS) payment – with more cuts slated to come into effect in CY2026. According to CMS, $4.5 billion more in future cuts is looming; this number that will likely be higher with the publication of the CY2026 payment rule. These FFS cuts, coupled with the inadequacy of payment and administrative burden of MA payments, have created an impossible fiscal situation for our home health providers.

[1] https://www.johnahartford.org/crossroads

MedPAC recently reported they do not think reductions in HHA Medicare FFS payment will deter HHAs from accepting FFS beneficiaries. We disagree. We believe that the continued overall fiscal situation, if unchanged, will cause HHAs to close, especially in rural and underserved areas, and will continue to compound an already existing access issue encapsulated in a recent report, "Half of U.S. counties have five or fewer home health agencies per 1,000 square miles, with many rural areas having access to only one agency or no agencies serving more than 10 patients…. Between 2019 and 2023, the number of skilled home health agencies that treated more than 10 [fee for service] patients annually decreased or remained the same in 94.1% of U.S. counties."[2]

We ask that the Congress consider the following home health policies:

- Ensure adequate payment for home health services by repealing the requirement that CMS adjust payment in aggregate based on provider behavior, eliminating the temporary retrospective payment adjustments, and examining ways to bolster the permanent baseline.

- Give additional reimbursement to home health providers in rural areas and to explore similar targeted payment adjustments for other underserved populations.

- Expand the Medicare home health benefit to ensure greater access to personal care services. Aides are a vital component of home health care, but downward trends in payment and increased scrutiny on aide utilization makes it challenging for providers to use aides.

- Amend the definitions of homebound and skilled care to achieve a more flexible and accessible benefit structure.

- Enact legislation to permenantly allow the home to be the originating site for telehealth services, removing telehealth geographic restrictions, and allowing a wider range of providers to bill for telehealth services.

- Enact the Medicare Home Health Accessibility Act (H.R.2013) to change the statutory language defining skilled needs for home health providers to align with other therapies and include occupational therapy as a qualifying home health service.

We also ask Congress to direct MedPAC and CMS to redefine home health access and address fraud. The current access definition, based on provider numbers per zip code, does not reflect the reality, as referral rejections are at an all-time high. We recommend examining referral rejections and their correlation with conditions or demographics that limit access to care. CMS and MedPAC should also assess the impact of Los Angeles County on the PDGM and Home Health Value Based Purchasing Model (HHVBP) baselines, particularly considering outlier metrics like low LUPA rates and no institutional admissions. Both should evaluate the validity of agencies contributing to these trends and recommend actions to ameliorate any findings.

Hospice

Hospice policy has not significantly changed since its inclusion in the Medicare program in 1982. Reforms will ensure greater access and better support for beneficiaries and their families. LeadingAge supports

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[2] Trella Health Special Report: HOME HEALTH ACCESSIBILITY AMONG MEDICARE FEE-FOR-SERVICE (FFS) BENEFICIARIES. (December 2024).

policies that expand access to care, reduce bad actors, promote sustainable reimbursement, and ensure the viability of high-quality providers into the future. A number of policies that support that vision were included in **the *Hospice Care, Accountability, Reform, and Enforcement (CARE) Act*** (H.R. 9803 in the previous Congress) as well as outlined in letters sent to CMS by Representatives Van Duyne, Blumenauer, Panetta, and Wenstrup in the last Congress. We ask that Congress enact legislation that will ensure earlier access to care and support for beneficiaries including:

- Payment for palliative therapies (e.g., palliative radiation, palliative dialysis) sustainably and consistently, which would increase timely enrollment in hospice.
- Expanding access to inpatient hospice care by creating a residential level of hospice care in the Medicare program, allowing patients to "step down" from more intensive services without a disruptive move and for those who prefer to die outside their home to do so with more supports.
- Expanding hospice to include a home-based respite level of care so caregivers can access respite even if they do not want to move their loved one to an inpatient respite bed.

Congress should continue the work led by Representative Van Duyne and Blumenauer in the last Congress to root out fraud and abuse in the hospice benefit, while protecting high quality hospice providers. We thank Representative Van Duyne for her work on the Special Focus Program and are glad to see the pause being taken by the current Administration. There is more work to do. We ask Congress to:

- Enact a moratorium on new hospices, with exceptions.
- Direct CMS to target hospices based on certain red-flag criteria developed in consultation with stakeholders. All targeting should adopt a matrixed approach – as the current system unfairly audits providers for legitimate practices, such as providing high levels of appropriate general inpatient care that is good for beneficiaries but makes them an outlier.
- Require CMS audit contractors to be transparent in their process and better target oversight resources.
- Prohibit payment to hospices that do not submit required quality data to the Secretary, with existing exemptions remaining in place.

Like all other health care providers, hospices struggle to maintain the workforce needed to effectively deliver quality care. We ask that Congress enact:

- The ***Improving Care and Access to Nurses (ICAN) Act*** (H.R. 1317/S. 574), to expand the APRN scope of practice, allowing them to certify terminal illness in hospice and to bill for physician services under the hospice benefit, even when they are not the attending physician.
- The ***Palliative Care and Hospice Education and Training Act (PCHETA)*** (S. 2243 in the 118th Congress) to support training of interdisciplinary health professionals in hospice and palliative care and authorizes grants to develop programs to train individuals to provide palliative care in hospital, hospice, home, or long-term care settings.
- Legislation to permanently eliminate geographic restrictions for telehealth, allowing the home as an originating site and enabling hospice face-to-face recertification via telehealth, as in the

CONNECT Act. While extensions like Rep. Miller's ***Hospice Recertification Flexibility Act*** (H.R. 1720) and the ***Telehealth Modernization Act*** are welcome, permanent policies are needed.

Palliative Care

We also ask that Congress instruct CMS to assign payment under Medicare Part B for outpatient and at-home palliative care services as well as defining a standard set of palliative care services for Part B. These payments and services should allow for a full, team-based approach to palliative care at a sustainable rate and be billable by the wide range of providers that engage in palliative care. This type of payment would add a layer of support across the post-acute continuum of care.

Long-Term Care Financing

In 2026, the oldest baby boomers will turn 80, and by 2030, the older adult population is projected to double, reaching 73 million and 21% of the U.S. population.[3] This growth, coupled with economic declines among those over 65, highlights the need for long-term services and supports (LTSS). Most Americans don't save for LTSS, and the government has no program in place. Family caregivers provide much of the care, but LTSS insurance has had limited success. Medicare doesn't cover ongoing LTSS needs, and Medicaid is limited to those with low incomes or assets, and those whose health costs drive them into poverty. We are concerned that Medicaid cuts would exacerbate the long-term care funding problem. While wealthier individuals can self-finance, the growing middle class has few options. We support proposals exploring multiple financing mechanisms, including expanding Medicare to cover LTSS and other alternatives outside of Medicare. We endorse the ***Well-Being Insurance for Seniors to be at Home (WISH) Act*** (H.R. 2082) by Representatives Suozzi and Moolenaar, as one of the much-needed solutions in this space.

Responding to Witness Testimony

PAC margins and impacts on Medicare Trust Fund Solvency

The PAC marginal profits cited by one of the hearing's witnesses were from MedPAC and reflect only the Medicare fee-for-service (FFS) marginal profit not the total margin. The 2025 MedPAC Report to Congress: Medicare Payment Policy projects an average 23% FFS Medicare margin in 2025 but reported an all-payer total margin for freestanding SNFs (reflecting all lines of business and all payers) in 2023 **was not as rosy at just 0.4%** with 46% of SNFs projected to have a negative all-payer total margin. MedPAC doesn't report all-payer margins for HHAs.

The report notes, *"Because the all-payer total margin includes Medicaid-funded long-term care, state policies regarding the level of Medicaid payments, including base rates and supplemental payments, significantly affect the overall financial performance of this setting… The continued expansion of enrollment in MA, with its lower payment rates, also factors into the total margin."*

For these reasons, MA penetration especially when concentrated in one to two plans is more financially precarious for SNF and HHA providers who have little leverage in these negotiations because of their size. We ask Congress to instruct CMS to begin more closely tracking and reporting market concentration and identifying mechanisms to protect providers and beneficiaries from the potential consequences that result.

[3] Older Americans 2020: Key Indicators of Well-Being (agingstats.gov)

The reality is that Medicare FFS subsidizes losses providers incur from other payers, such as Medicaid and now, Medicare Advantage. This low overall margin is also reflective of the fact that MA plans and Accountable Care Organizations have been reducing post-acute care utilization.

One witness claimed PAC expenditures are driving Medicare Trust Fund insolvency and yet neglected other contributing factors such as rising enrollment, higher care costs, and excess payments MA plans. Since the IMPACT Act's passage in 2014, Medicare enrollment has grown from 54 million to 67 million and now more than 50% of these older adults are enrolled in MA. MedPAC estimates MA plans are paid 22% more ($83 billion) than Medicare FFS for these MA enrollees, primarily due to coding intensity and favorable selection. We encourage Congress to address these insolvency concerns.

Unified Post-Acute Care Prospective Payment System (UPAC)

While preserving the Medicare Trust Fund is a shared goal, the UPAC was flawed, and its rationale has been addressed through changes in PAC payment methodologies and cost control via increased MA enrollment (from 30% in 2014 to 54% in 2024) and the expansion of ACOs. As a result, there are limited savings left in FFS expenditures.

The IMPACT Act of 2014 aimed to transition post-acute care payments from service volume to patient clinical conditions. Since then, PAC payment models like the SNF Patient Driven Payment Model (PDPM) (2019) and Home Health Patient Driven Groupings Model (PDGM) (2020) have been implemented.

With 54% of beneficiaries enrolled in MA and half of traditional Medicare beneficiaries in Accountable Care Organizations (ACOs) managing PAC costs, only about 25% remain in traditional FFS. We have submitted more detailed testimony with other PAC provider associations and will not repeat it here.

The Bottom Line

Provider payment pressures jeopardize beneficiaries access to quality services. Health plan cost containment measures such as prior authorization and claims adjudication add to providers' and taxpayer costs and administrative burden. Regulations that present barriers to beneficiaries accessing care or may result in a retraction of PAC services should be reconsidered or eliminated.

We commend the Committee for exploring factors affecting beneficiary access to PAC and urge it to ensure adequate payments from all payer sources so providers can invest in innovation and continue serving vulnerable adults. We ask the committee to preserve Medicaid funding and ensure MA plans pay their fair share for PAC services. Congress and the Administration lack data on prior authorization costs, claims adjudication, and MA plan encounter data, hindering effective oversight. Standardizing processes like prior authorizations, claims payments, and codes in MA could reduce costs and administrative burdens and expedite care for beneficiaries.

Again, we appreciate the opportunity to share our concerns and look forward to working with you in crafting solutions to these issues that currently jeopardize older adult access to care and services. Please let us know how we can further support your endeavors to improve post-acute and long-term services for older adults. Please contact Nicole Fallon with any questions or follow up at nfallon@leadingage.org.