AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

January 26, 2026

The Honorable Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4212-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted Electronically

Re: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program (CMS-4212-P; RIN: 0938-AV63)

Dear Administrator Oz:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) *Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program* proposed rule (the "Proposed Rule").[1] AMRPA is the national trade association representing more than 800 inpatient rehabilitation hospitals and units (referred to by Medicare as Inpatient Rehabilitation Facilities, or "IRFs"). Our members focus on the care and functional recovery of some of the most vulnerable Medicare beneficiaries – such as individuals with stroke, traumatic brain injury, spinal cord injury, limb loss or amputation, and a wide array of neuromuscular and musculoskeletal conditions. AMRPA member hospitals help patients maximize their health, functional ability, independence, and participation in their communities, so they are able to return to home, work, or an active retirement.

IRFs play a unique and critical role in providing hospital-level medical and rehabilitation care to beneficiaries in Traditional Medicare and those enrolled in Medicare Advantage (MA) plans. It is vital that both patient populations have equivalent access to medically necessary inpatient rehabilitation services. Unfortunately, many MA enrollees face significantly reduced access to inpatient rehabilitation care, a trend which has been consistently validated by the Medicare Payment Advisory Commission (MedPAC) as well as our internal data collection efforts from AMRPA members, described in more detail below.

This year's Proposed Rule focuses heavily on regulatory changes to Medicare Part D (implementing changes from the *Inflation Reduction Act*), as well as updates to the Medicare

[1] Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program, 90 Fed. Reg. 54,894 (proposed Nov. 28, 2025).

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Advantage and Part D Star Ratings Program. The Proposed Rule includes only minimal provisions addressing AMRPA's primary concerns with the Medicare Advantage program: prior authorization and access to medically necessary IRF care for beneficiaries. AMRPA recognizes the Administration's early actions to address the overuse and misuse of prior authorization in Medicare Advantage, including the voluntary commitments reached with major insurers in June 2025, and we thank you for your leadership on these efforts.

Despite initial optimism regarding these actions, unfortunately, inpatient rehabilitation providers across the nation have yet to see meaningful results. Our member hospitals continue to report that Medicare Advantage plans erect severe barriers to access and payment, delaying or preventing Medicare beneficiaries from receiving the care they need. AMRPA thus reiterates several of our longstanding requests for meaningful policy reforms in the Medicare Advantage program that will help ensure America's seniors and people with disabilities realize the full promise of Medicare coverage, in accordance with the Administration's goals of reducing burden, increasing transparency, and expanding access to timely, evidence-based care. Below, we detail four primary areas for CMS' consideration:

- **The agency should take concrete steps to meaningfully increase transparency around MA plan behaviors, including:**
  - **Collecting and publicly reporting disaggregated, service- and setting-specific data from MA plans on prior authorization requests, approvals, denials, and appeals; and**
  - **Reinstating public reporting on the Independent Review Entity appeals database.**
- **The agency should refocus and expand its efforts to enforce MA plan compliance with existing program requirements to protect both MA beneficiaries and the Medicare program's bottom line.**
- **The agency should improve meaningful network adequacy in Medicare Advantage by including inpatient rehabilitation hospitals in the mandatory provider list for plan networks.**
- **The agency should investigate, and if necessary, take action to address increasing reports of MA plans potentially misusing or abusing the administrative appeals process to delay and deny the provision of medically necessary care.**

We believe that these areas are ripe for timely, effective CMS action to ensure a Medicare Advantage program that lives up to the program's goals and the needs of the enrollee population.

I. State of Play for IRF Access in Medicare Advantage

For years, AMRPA members have reported that MA plans routinely and consistently divert beneficiaries away from IRFs to less intensive settings of care through the misuse and abuse of prior authorization and other utilization management techniques. Independent data analyses consistently indicate that MA beneficiaries have significantly less access to IRF care than their counterparts in Traditional Medicare, with MA beneficiaries' access to and utilization of IRF

care ranging from one-third to one-half the rates of Traditional Medicare beneficiaries.[2] AMRPA's own analysis of data published by CMS indicates that in Fiscal Year (FY) 2024, the annual IRF discharge rate per 1,000 beneficiaries for Medicare Advantage was just 4.7 compared to 13.14 in Traditional Medicare.[3]

AMRPA members report that this stark disparity in access arises from the continued reliance by plans on internal coverage criteria to deny authorization for IRF admissions, the use of prior authorization as a burdensome delay tactic to shift beneficiaries to lower-cost settings, and in many cases, the denial of authorization for patients who clearly meet the existing criteria for IRF coverage. In October 2024, the Senate Permanent Subcommittee on Investigations released a report highlighting the dramatic rise in denial rates for post-acute care services across the largest MA insurers, which were substantially higher than overall denial rates for non-post-acute care services.[4] Similarly, a 2024 survey of AMRPA members found that more than 57% of all initial requests for an IRF admission were denied during a two-month period, resulting in nearly 70,000 days spent waiting in the acute care hospital in just those two months.[5] If these trends were extrapolated to the approximately 1,200 IRFs nationwide for the 2024 calendar year, this would represent as many as *1.2 million* waiting days due to prior authorization alone, all before an initial decision was even rendered.

Such inappropriate delays and denials of post-acute care admissions have a direct negative impact on beneficiaries' long-term health, function, and their ability to maximize their recovery. Not only are beneficiaries' recoveries threatened by unnecessary prior authorization delays, but these delays have severe ripple effects across the entire health care system. Delays in approving discharges to post-acute care cause backups in the acute care hospitals, when beneficiaries in need of medical rehabilitation are instead left to languish in a hospital bed that could be used by another incoming patient in need of acute care, in turn backing up new admissions from emergency departments and other admission sources, all while artificially increasing lengths of stay. All of these impacts increase costs to acute care hospitals and the Medicare program, while decreasing actual benefits to patients.

More recently, our members report that MA plans are dramatically increasing their use of retroactive, post-payment review (more commonly known as "clawbacks"), wherein plans or

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[2] *See, e.g.,* Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, 272 (Mar. 2017) (finding that MA enrollees receive one-third the access to IRF care that is afforded to Traditional Medicare beneficiaries); KNG Health Consulting, "Medicare Advantage Enrollees Almost Half as Likely to Receive Inpatient Rehabilitation as Compared to Fee-for-Service Enrollees," (Nov. 20, 2025), https://www.knghealth.com/medicare-advantage-enrollees-almost-half-as-likely-to-receive-inpatient-rehabilitation-as-compared-to-fee-for-service-enrollees/.

[3] Figures derived from AMRPA analysis of FY 2024 total admissions data and Medicare Monthly Enrollment file.

[4] U.S. Senate Permanent Subcommittee on Investigations, Majority Staff, *Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care* (Oct. 17, 2024). Available at: https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf.

[5] The 2024 AMRPA survey, administered in July and August of 2024, represents a total of 367 IRFs from 48 states and Puerto Rico. The data reflects the outcomes of more than 27,000 prior authorization requests. The full survey results and methodology are available here: https://amrpa.org/medicare-advantage-prior-authorization-survey/.

third-party contractors will contradict their own decisions in cases where they actually did provide prior authorization. These clawbacks can come weeks, months, or even years after care has been provided, a patient has been discharged, and payment has been rendered. The end result of these tactics is that our members have to fight on both the front and back ends just to receive payment for medically necessary care provided in accordance with Medicare rules, and hospitals and health systems are left unable to rely on their own cash flow because settled payments are subject to retroactive recoupment attempts at any point.

This situation has persisted for years, despite consistent and clear statements from CMS, in regulation, that MA plans must abide by the Traditional Medicare coverage criteria specific to IRFs, which constitute "fully established coverage criteria" under the definition advanced by CMS.[6] By meeting this coverage standard, MA plans are required not to impose their own coverage requirements on IRF admissions, as there should be no need to augment fully established coverage criteria. Clearly, prior authorization and access to care in Medicare Advantage remain serious issues in the post-acute care space, and we urge CMS to prioritize meaningful reforms to address this crisis. Below, we discuss four major areas for regulatory action that fall well within the scope of current agency authorization.

II. Increasing Transparency around the Use of Prior Authorization

This Administration, across the entire Department of Health and Human Services and within CMS, has consistently espoused its commitment to radical transparency. This has been reflected in the June 2025 voluntary insurer pledge, with major insurers committing to enhancing transparency and communication around authorization denials and appeals. Despite this commitment, patients and providers still lack meaningful transparency around the use of prior authorization, especially in post-acute care, and we urge CMS to mandate that plans share relevant, useable data both with the agency and the public, especially as beneficiaries seek to make critical decisions about where to get their coverage.

To date, existing CMS requirements only mandate that MA plans publicly report plan-wide prior authorization metrics, beginning this calendar year. AMRPA has long urged CMS to expand these requirements to include disaggregated, service- and setting-specific data on prior authorization requests, approvals, denials, and appeals. While we support any increase in prior authorization transparency, the current plan-level data will be too broad to be useful for patients, providers, and other stakeholders. We are particularly concerned that the vast amount of prior authorization data included in plan-level metrics (such as prior authorization requests for all routine diagnostic services) will obscure necessary information about trends relating to comparatively lower-volume services, such as inpatient rehabilitation hospital admissions. It is

[6] 42 C.F.R. § 422.101(b)(2): "[Each MA organization must comply with] General coverage and benefit conditions included in Traditional Medicare laws, unless superseded by laws applicable to MA plans. This includes criteria for determining whether an item or service is a benefit available under Traditional Medicare. For example, this includes payment criteria for inpatient admissions at 42 CFR 412.3, services and procedures that the Secretary designates as requiring inpatient care at 42 CFR 419.22(n), and requirements for payment of Skilled Nursing Facility (SNF) care, Home Health Services under 42 CFR Part 409, ***and Inpatient Rehabilitation Facilities (IRF) at 42 CFR 412.622(a)(3)***" (emphasis added).

imperative that enrollees, caregivers, and oversight entities have access to robust, specific information regarding the types of items and services for which plans may be unfairly restricting access or issuing erroneous prior authorization determinations that are ultimately overturned in favor of patients and providers.

Unfortunately, we have seen CMS recently take steps backward, not forward, with regards to the critical need for prior authorization transparency. In this Proposed Rule, CMS proposes to eliminate entirely the requirement that MA plans publish an annual health equity analysis on the use of prior authorization. CMS states that the agency "now believes that this analysis is not the best vehicle to obtain baseline data on the use of prior authorization and that there are more effective ways to gain this information."[7] While we recognize that the Administration's priorities have evolved and there is a move away from the health equity analysis process, we are concerned that critical transparency goals are an inadvertent casualty of this shift, and we urge CMS to move quickly to develop, propose, and adopt "more effective ways" to gather this data.

We also note that CMS previously indicated its intention to begin collecting service-level prior authorization data from all plans, but recently modified that proposal into a voluntary "pilot program" for which the agency is currently accepting applications.[8] AMRPA strongly supported the collection of this data on a mandatory, program-wide basis.[9] AMRPA appreciates CMS' care in seeking to make refinements to the data collection process before expanding the program to all plans, but we urge CMS to prioritize a rapid and robust expansion of this data collection as soon as practicable. Further, we urge CMS to not only collect such information internally, but to publicly report the information collected by plans, so that patients and providers can adequately evaluate the decision-making process of plans on prior authorization requests. AMRPA continues to recommend that such information be publicly posted on a consumer-facing and consumer-friendly site, similar to the way that beneficiaries can use Care Compare to help make decisions about IRF care and other post-acute care services.

Finally, we note that CMS previously published robust information on the Reconsideration by an Independent Review Entity (IRE) process in Medicare Advantage through the Appeals Decision Search database.[10] This information was of critical importance to beneficiaries, providers, and other stakeholders in better understanding how the IRE (Maximus) conducted reviews of plan denials of care. Unfortunately, the agency has recently eliminated updates to the database, without providing any justification or notice beyond an acknowledgement that "Part C decisions will not be updated past May 5, 2025." We urge the agency to reconsider this decision, quickly reinstitute regular updates to the database and provide retroactive information on appeals and reconsiderations in the interim.

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[7] Proposed Rule at 54,989.

[8] CMS Memo, Service Level Data Collection for Initial Determinations and Appeals – Pilot Participation (Dec. 16, 2025) (available at: https://sponsors.aha.org/rs/710-ZLL-651/images/AT-121725_HPMS%20Memo_Service%20Level%20Data%20Collection%20Pilot%20Participation_508.pdf).

[9] AMRPA Comments re: Service Level Data Collection for Initial Determinations and Appeals (CMS-10905), submitted Oct. 8, 2024 (available at: https://amrpa.org/wp-content/uploads/2024/10/AMRPA-Comments-on-CMS-ICR-Service-Level-Data-Collection_FINAL.pdf).

[10] Available at https://www.cms.gov/medicare/appeals-grievances/appeals-decision-search-part-c-d.

AMRPA firmly believes that transparency in the Medicare Advantage prior authorization and appeals process is a prerequisite, not an optional feature, for a functional Medicare program that ensures beneficiaries get the care they need, that they and the federal government pay for, in the right place, and at the right time. As the Administration continues to work with insurers on voluntary reforms to the prior authorization process, radical transparency in the day-to-day practices of health plans is critical to evaluating the success of these efforts and identifying further actions to be taken.

III. Ensuring Meaningful Compliance with Existing Requirements

In addition to the important transparency provisions detailed above, AMRPA notes that Medicare Advantage plans already operate under robust requirements governing their responsibilities to provide medically necessary care to beneficiaries nationwide. In particular, AMRPA greatly appreciates the steps the agency took towards reining in inappropriate MA plan practices in the Contract Year (CY) 2024 MA final rule.[11] Many of the provisions in this final rule were directly responsive to long-held concerns and recommendations from AMRPA and many of our partner organizations, and we thank the agency for their continued attention and action on these matters. However, these new requirements were not accompanied by any meaningful enforcement mechanism, and the Administration has an important opportunity to make lasting changes across the MA program by capitalizing on the regulatory language already available to the agency.

Among other provisions, current regulations as finalized in that rule mandate that plans adhere to requirements regarding the qualifications and experience of plan reviewers issuing denials based on medical necessity; institute limits on re-authorizations for already-approved "courses of treatment;" restrict the use of proprietary guidelines or other internal coverage criteria, and require that MA plans comply with all Traditional Medicare statutes, regulations, and other applicable coverage requirements.

Unfortunately, many IRFs and other post-acute care providers have reported little, if any, changes in plan behavior since these requirements went into effect on January 1, 2024. AMRPA consistently receives reports from member hospitals of denials that appear to directly contradict explicit coverage requirements, such as denial letters explicitly citing proprietary guidelines as the reason for denial (including Milliman Care Guidelines/MCG, InterQual, or unspecified "internal criteria")[12], as well as denials offering statements such as, "You could receive treatment at a lower level of care," "The care you require can be rendered in an alternate setting," and "Needs could be met at a lower level," without any additional finding that the IRF admission otherwise did not meet the fully established coverage criteria under Traditional Medicare.[13] This

[11] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 88 Fed. Reg. 22,120 (April 12, 2023).

[12] Explicitly prohibited under 42 C.F.R. § 422.101(b), (c), and § 422.566(d).

[13] This "less intensive setting" standard comes directly from a rescinded ruling, HCFA Ruling 85-2, which CMS withdrew in 2010 and replaced with the updated IRF coverage regulations at 42 C.F.R. § 412.622. The current

indicates that many patients may be denied access to an appropriate level of care for their condition (as determined by their treating physician and clinical team), and such diversions to less intensive settings are not adequately represented in the data currently available.

Regarding reviewer qualifications, hospitals continue to report instances where the clinician making the denial (and overriding the clinical judgment of the rehabilitation physician actually treating a given beneficiary) have experience or specialties far outside the realm of medical rehabilitation, including pediatric gastroenterology, family medicine, anesthesiology, and others.[14] We have also received reports that plans refused to provide any background information on the clinician making a denial, even if that clinician is actively engaged in a peer-to-peer discussion with the treating rehabilitation physician. Finally, our members often report that plans are inappropriately erecting barriers to receiving timely decisions or accessing the peer-to-peer calls necessary to receive a final decision on a given course of treatment. All of these actions run counter to the expressed commitments by major insurers to reform and reorient the prior authorization process to be more patient-centered that this Administration spearheaded and promoted last year.

Therefore, AMRPA urges CMS to re-prioritize and refocus its efforts on enforcing compliance with existing Medicare Advantage rules and regulations in Contract Year 2026, 2027, and beyond. We firmly believe that the agency has the necessary "tools in its toolbox" to make meaningful change to support the more than 35 million individuals in the MA program and allow them to receive the care to which they are entitled. Combined with increased transparency and data collection on MA plan practices, robust CMS enforcement of existing rules can help ensure that the Medicare program works for all of America's seniors and people with disabilities, regardless of how they choose to access their coverage.

IV. Enhancing Network Adequacy Standards for MA Plans

The Proposed Rule includes a request for comment on simplifying and streamlining the network adequacy review process for MA plans. AMRPA urges CMS to ensure that any future revisions to the MA network adequacy requirements include necessary enhancements to protect access to care by adding inpatient rehabilitation facilities to the network adequacy list at 42 C.F.R. § 422.116. In our members' experience, many MA plans limit access to IRF care by keeping their IRF provider network narrow and inadequate to meet beneficiary demand. AMRPA members report that numerous MA plans nationwide do not maintain a sufficient number of agreements

coverage criteria established by Medicare for the IRF benefit does not include a standard to deny admission to a patient that could theoretically receive care in a less intensive setting. As long as beneficiaries otherwise meet all IRF coverage criteria established in regulation, they are appropriate for an IRF admission.

[14] 42 C.F.R. § 422.566(d) requires that an MA plan's determination must "be reviewed by a physician or other appropriate health care professional with expertise in the field of medicine or health care that is appropriate for the services at issue." In cases involving IRF services, MA plans are required to appoint an appropriate health care professional "with expertise" in both the field of inpatient rehabilitative care and in the Medicare coverage criteria for inpatient rehabilitative care, with CMS specifically stating that a reviewer "would need to have the background and knowledge to determine that the enrollee's medical condition requires intensive rehabilitation, continued medical supervision, and coordinated care."

with all types of post-acute care providers (particularly IRFs) due in part to the fact that there are no network adequacy requirements for MA plans to include IRFs in their networks. The omission of IRFs on the network adequacy list may also render beneficiaries insufficiently informed as to their option to be discharged from an acute care hospital to an IRF level of care when they otherwise qualify for admission under the Medicare IRF coverage criteria. Even when beneficiaries are able to overcome this unnecessary information gap, IRF access may still be restricted by the considerably higher costs borne by beneficiaries when their IRF service options are out-of-network.

We note that there has been longstanding, bipartisan support in Congress for a regulatory remedy to this network adequacy issue. In September 2024, more than 50 Members of Congress urged CMS to fix this oversight, noting the importance of protecting patient access to comprehensive, person-centered care in MA commensurate with the Traditional Medicare program.[15] We also note that this provision has widespread support from the rehabilitation, disability, clinical, and consumer communities. We believe this is a critical change that would meaningfully impact patients' ability to access the care they need, in the most appropriate setting for their condition, regardless of the source of their Medicare coverage. Therefore, as CMS considers modifications to the outdated network adequacy requirements to streamline the review process, we urge the agency to also require MA plans to include IRFs in their networks.

V. MA Plan Overuse of the Fourth Level of Administrative Appeal to Delay and Deny Care

Finally, several AMRPA members have recently reported a new trend emerging, in which several MA plans appear to be routinely appealing many or all claims that are decided in favor of patients/providers at the Administrative Law Judge (ALJ) level further to the Medicare Appeals Council (MAC) within the Departmental Appeals Board. This is permissible under the existing administrative appeals process, but given the lengthy backlog of appeals at the MAC, exercising this additional level of appeal has the effect of further delaying a coverage determination, oftentimes for several years, by which time the beneficiary has lost the window of opportunity to improve or regain their health and function with IRF care, and may often be significantly compromised as a result.

When Traditional Medicare IRF admissions are denied and appealed, the patient has already received the benefit of inpatient hospital rehabilitation services and the claim amounts to a dispute of payment between the Medicare program and the provider; the beneficiary is held harmless in these situations. But when a prior authorization request is denied by an MA plan and is consistently appealed despite multiple findings in favor of the patient and provider, the patient must wait until a final determination has been made as the denial works its way through the administrative appeals process. Based on the reports of how frequently these higher-level denials are occurring, we have serious concerns that MA plans are not appealing these decisions based on a substantive review of the medical necessity of the claim, but instead as a matter of course,

[15] *See* Rep. Beth Van Duyne (R-TX) Letter to CMS, Sept. 30, 2024, available at: https://amrpams.informz.net/AMRPAMS/data/images/MA%20Network%20Adequacy%20-%20Final%20Letter%20with%20Signatures%209.30.24.pdf.

recognizing that many patients in serious need of care may abandon the appeals process and seek care elsewhere, or be unable to sustain the appeal when they are at their most medically fragile. We urge CMS to further examine what appears to be an emerging tactic of MA plans to further delay and ultimately deny coverage for IRF care, and to take action if necessary.

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AMRPA greatly appreciates CMS' continued efforts to reform the use of prior authorization and other barriers to access in the MA program. We look forward to continuing our collaboration with CMS to ensure that all Medicare beneficiaries have timely access to the care they need, particularly with respect to medically necessary inpatient hospital rehabilitation services. Should you have any questions or wish to discuss our comments further, please contact Kate Beller, AMRPA President, at KBeller@amrpa.org and Joe Nahra, Director of Government Relations & Regulatory Policy, at JNahra@amrpa.org.

Sincerely,

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