AMRPA Response to GAO Interview Questions Regarding IRFs & Medicare Advantage Networking Issues

AMRPA appreciates the opportunity to respond to the Government Accountability Office's (GAO) inquiries into Medicare Advantage networking and related coverage issues impacting post-acute care providers. Our answers reflect AMRPA member reports, an AMRPA survey, and well-established AMRPA advocacy positions around MA reform. While AMRPA appreciates GAO's specific interest in issues related to MA plan contracting covered in this report, AMRPA encourages GAO to also examine other MA tactics that have direct impacts on care delays and denials in future work. We stand ready to provide additional technical assistance in the GAO's pending report as well as any subsequent work on these critical issues.

I. To what extent do your members participate in MA networks?

AMRPA members report that inpatient rehabilitation facilities (IRFs) make every reasonable effort to participate in Medicare Advantage (MA) networks given that the IRF patient population is dominated by Medicare and MA patients, and the exclusion of MA patients would therefore create significant access (and IRF volume) issues. For these reasons, however, MA plans carry disproportionate clout in contract negotiations, and plans use this advantage in the context of rate negotiation and other matters. Barring egregious tactics, however, IRFs are generally compelled to accept suboptimal contract terms rather than face exclusion from networks – particularly from larger plans.

More commonly, MA plans are the ones who deny IRF providers' efforts to participate in their networks, stating that they have already satisfied their network adequacy requirements. Major IRF providers have challenged these determinations without success due to the deficiencies in the current network adequacy regulatory standards (discussed more below). Furthermore, once network adequacy standards are met, IRF providers have even less negotiating leverage, regardless of the quality and long-term value of the care provided.

Regarding specific IRF representation in MA networks, IRF participation is tied largely to patient demographics, though regional MA market penetration also plays a role. Individual AMRPA member submissions will offer additional color as to other specific factors that drive MA network participation and what factors may drive disparities based on geography, IRF structure (unit versus freestanding), and other factors.

II. Do your members report any issues or concerns when negotiating their contracts with MAOs? If yes, what is the nature of those issues or concerns?

AMRPA members report multi-faceted issues in their contract negotiations with MAOs. IRFs commonly report reimbursement challenges, as MA plans often use tactics to push reimbursement rates below Medicare benchmarks and use skilled nursing facility (SNF)-level prices to establish substandard market rates of reimbursement. In addition, IRF providers report egregious delays in

executing contracts and provider credentialing with MA plans (which creates disruptions and confusion when these delays roll into the coverage year), lack of transparency as to how claim payments are calculated, poor adherence to CMS guidelines, and other administrative complexities.

III. Do your members report any issues or concerns when providing care to MA enrollees as either in-network or out-of-network providers? If yes, what is the nature of those issues or concerns?

Regardless of whether patients are in-network or out-of-network, AMRPA members universally cite issues with delays in obtaining prior authorization for IRF care, unjustified denials for IRF admissions, and the numerous and extensive barriers that patients and providers face when appealing these adverse determinations. Even if IRF care is ultimately authorized, patients are negatively impacted by prolonged stays in the acute-care hospital, prolonging or complicating their ultimate recovery. A 2024 AMRPA member survey highlighted the magnitude of these behaviors, finding that MA plans overrule rehabilitation physician judgment by denying admissions at a rate of more than 57%; these denials resulted in more than 67,000 days waiting for determinations across the two-month survey window.

When IRFs are out-of-network providers for MA enrollees, additional problems arise for both patients, IRFs, and the acute care hospitals. Per AMRPA members, MA plans require even more extensive reviews when IRFs are out of network, report higher denial rates, and impart confusion on the part of patients regarding their financial responsibility. On the latter point, patients that are referred to out-of-network IRFs (due to IRF being the most clinically appropriate setting) may be forced to decline this medically necessary care due to concerns regarding the significantly higher out-of-network costs. These out-of-network issues collectively result in acute-care hospital backlogs, increase administrative burdens for all providers involved, and negatively impact patient outcomes by diverting patients to inappropriate settings.

IV. How frequently do your members and MAOs not renew their contracts?

For the reasons outlined above, IRF providers overwhelmingly prefer to participate in-network and continually renew contracts with MA plans. Providers would cease their participation only under egregious reimbursement conditions such as persistent payment issues and extensive administrative burden. Typically, contracts with large, national plans are rarely terminated (at least on the part of the IRF) due to the provider's dependence on the large patient volume the plans provide. Based on anecdotal member reports, the most common terminations are with those smaller plans with consistent payment failures and excessive denials.

V. For your members who are not in an MA network or that leave an MA network, what share see MA enrollees as out-of-network providers?

When IRF providers are designated as an "out-of-network" provider, a risk of increased financial burden discourages patient utilization. The relatively higher cost of IRF care is driven in large part by the physician-led, interdisciplinary rehabilitation care that furnishes intensive therapy and round-the-clock rehabilitation nursing to help patients regain function and return to the community.

Therefore, despite the medical need for and likelihood of superior outcomes associated with IRF services, patient access can be functionally restricted by expenses that are not covered or out-of-pocket.

VI. Are you aware of any problems with MA enrollee access to post-acute care providers? If so, please discuss.

Access to care – particularly in the MA program – is one of AMRPA's core advocacy priorities. Just this month, the HHS OIG released a report that found that MA organizations denied on average 43% of IRF admission requests, with UnitedHealth Group, Inc posting a 66% denial rate. Upon appeal, the OIG found that MA plans collectively overturned nearly half (43%) of IRF denials, with some plans reporting an overturn rate as high as 86%.[1] This is highly consistent with AMRPA's own member survey, which found that MA plans deny initial referrals at a rate of more than 57%; these denials resulted in more than 67,000 days waiting for determinations across the two-month survey window.

Furthermore, an April 2026 MedPAC analysis[2] found that the MA share of Mediare IRF days was substantially lower than the overall MA market penetration (based on 2024 data). Specifically, the median MA market penetration was 55%, while the median MA share of Medicare IRF days was 24%. MedPAC analysis also showed the variation in access to IRF care based upon clinical condition, where MA patients with non-traumatic brain injury, cardiac conditions, other neurologic conditions, and orthopedic disorders had a lower share of Medicare IRF days than the overall Medicare population. AMRPA strongly believes that access to IRF care should be consistent with the MA market penetration, and that access to IRF care should be based upon the Medicare coverage requirements and not arbitrarily impacted by payer or condition.

VII. Are there any steps that CMS could take to better ensure access to post-acute care for MA enrollees?

AMRPA has recommended that CMS take numerous steps to meaningfully address MA access for IRF providers, while recognizing certain changes will require statutory action.

Increased Transparency Around MA Plan Tactics and Coverage Trends: In its aforementioned report, HHS OIG recommends CMS regularly collect request-level prior authorization data that include service type and contractor information. It also recommends that CMS assess reasons for the wide variation in IRF denial and overturn rates across MAOs and contractors and take action as appropriate. AMRPA strongly supports OIG's conclusions and recommends CMS increase transparency around MA plan behaviors, including the collecting and publicly reporting disaggregated, service- and setting-specific data from MA plans on prior authorization requests, approvals, denials, and appeals by plan, parent organization, and provider/service category. Furthermore, AMRPA urges

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[1] *The Three Largest Medicare Advantage Organizations Denied Requests for Long-Term Acute Care and Inpatient Rehabilitation at Some of the Highest Rates.* https://oig.hhs.gov/documents/audit/11693/OEI-09-24-00330.pdf

[2] Estimated association between Medicare Advantage enrollment and hospitals' and post-acute care providers' finances https://www.medpac.gov/wp-content/uploads/2025/08/Tab-G-MA-effects-on-providers-April-2026.pdf

CMS to reinstate public reporting on the Independent Review Entity appeals database and apply meaningful oversight of its results.

Network Adequacy Standards: Perhaps most specific to networking issues, CMS should include inpatient rehabilitation hospitals in the mandatory provider list for plan networks to better protect MA patient access to care. This would also require the development of network adequacy standards specific to inpatient rehabilitation providers and a mechanism for robust plan oversight.

Regulations Around "Peer to Peers": The peer-to-peer review is a critical step in reviewing the medical necessity of a coverage decision. In practice, however, these reviews are largely unregulated, and AMRPA members report a myriad of issues – ranging from timing to reviewer qualifications. Some of the most common concerns include "peer" reviews who do not hold any rehabilitation experience (or even familiarity), very limited review windows that can prevent physician participation, and lack of follow-up after a review. AMRPA therefore recommends that CMS adopt clear and consistent rules around peer-to-peers that would apply to all plans. These rules would require that peer-to-peer reviews are conducted by qualified rehabilitation physicians, occur prior to adverse coverage determinations, and are administered in a timely and transparent manner. Peer-to-peer review should facilitate clinically informed decision-making and beneficiary access to medically necessary inpatient rehabilitation care, rather than serve as an administrative barrier.

Prohibiting Coverage Standards in MA that Veer from Regulatory Criteria: Currently, consistent and clear statements from CMS exist in regulation requiring MA plans to abide by the Traditional Medicare coverage criteria specific to IRFs, which constitute "fully established coverage criteria" under the definition advanced by CMS.[3] MA plans, therefore, are not allowed to impose their own coverage requirements or alternative criteria on IRF referrals, and accordingly, MA and FFS utilization data should be similar. While there are certain regulatory safeguards designed to prevent coverage disparities, AMRPA's survey and other data show that oversight and enforcement of these rules must be strengthened as part of CMS' efforts to address these variances across FFS and MA.

Addressing Post-Payment Review Abuses: More recently, AMPRA members report that MA plans are dramatically increasing their use of retroactive, post-payment review (more commonly known as "clawbacks"), wherein plans or 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, while facing serious financial uncertainty for care already provided.

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[3] 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).

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VIII. Are there any other concerns that your members have regarding MA provider networks that we should be aware of?

In recent months, IRFs have reported a new trend emerging, in which 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. In contrast to MA plans, patients are restricted in their right to appeal determinations as they are often considered to have little to no "financial stake" in the outcome. This is particularly problematic for the dual-eligible Medicare population.

In addition, AMRPA is also aware of evolving payer tactics that impact access to IRF care and the transparency of MA plan decisions. One tactic of particular concern is the use of predetermination peer-to-peer requests prior to a formal authorization decision. The process functions as an extension of the payer's utilization review process and often leads to a negotiated outcome that aligns with denial or redirection of care. Thet predetermination P2P creates the perception that physicians and case managers are actively advocating for patient access as these discussions frequently result in an agreement to pursue a lower level of care (e.g., SNF vs. IRF) and avoid a formal denial determination. Because these cases may not result in a formal denial the outcome is not consistently captured in denial reporting metrics, which underrepresents the true volume of access barriers. This creates a lack of transparency for providers and regulators and difficulty tracking systemic access limitations within MA networks. This also impacts care delivery, as care teams may believe they have exhausted advocacy pathways when, in reality, the process is limiting escalation opportunities and shifting decision-making toward payer-preferred outcomes. Over time, this contributes to behavioral change in referral patterns, increased hesitation to pursue IRF placement for MA patients, and a greater likelihood of defaulting to lower-intensity settings.

IX. Are there any other organizations that you recommend we speak with? Are there any resources or research that you recommend we review?

AMRPA recommends GAO speak with the Center for Medicare Advocacy, the Coalition to Preserve Rehabilitation ("CPR Coalition"), and the American Academy of Physical Medicine and Rehabilitation ("AAPM&R"), as well as the other national post-acute care trade associations. GAO should also consider the data and findings from the following sources:

- Senate Permanent Subcommittee on Investigations report, "Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care on MA denials/delays"
- NORC at the University of Chicago study, *Analysis of Hospital Discharges to PAC Settings Among Medicare Beneficiaries*
- Internal data provided by hospitals and health systems

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Thank you for the opportunity to participate in and provide input on GAO's review of Medicare Advantage Provider networks. If you have any questions, please do not hesitate to contact Kate Beller, AMRPA President (202-207-1132, kbeller@amrpa.org)

Sincerely,

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