



June 16, 2026

Post-Acute Care Medicare Advantage Coalition Statement on OIG Reports Confirming Barriers to Post-Acute Care in Medicare Advantage

WASHINGTON, D.C. — The Post-Acute Care Medicare Advantage (PAC MA) Coalition issued the following statement in response to the U.S. Department of Health and Human Services (HHS) Office of Inspector General's (OIG) two new reports, [*The Three Largest Medicare Advantage Organizations Denied Requests for Long-Term Acute Care and Inpatient Rehabilitation at Some of the Highest Rates*](#) and [*Medicare Advantage Organizations Overturned Nearly All Appealed Prior Authorization Denials for Skilled Nursing Facility Admission, Raising Concerns About Initial Denials*](#):

"The PAC MA Coalition has long championed critical yet commonsense and necessary reforms to ensure Medicare beneficiaries' access to medically necessary care across all post-acute settings. These June 2026 OIG reports provide important, independent confirmation of what providers and Medicare beneficiaries have experienced for years: Medicare Advantage (MA) plans are using prior authorization (PA) and similar tactics to restrict beneficiaries from receiving the services that Medicare Advantage Organizations (MAO) are legally required to provide.

Across the post-acute care (PAC) continuum, OIG found concerning denial patterns, wide variation of the rate of denials among MA organizations, and high rates of successful appeals. Even when a denial is later overturned, the patient may still have faced unnecessary care delays, a prolonged hospital stay, an interruption in recovery, or placement in a less appropriate care setting. Given each PAC setting's distinct role and value in the rehabilitation continuum, these outcomes can cause significant disruptions

in patients' recovery trajectory and place patients at higher risk for complications and readmissions – all of which produce poorer outcomes and increase costs for the Medicare program.

For Medicare beneficiaries recovering from serious illness, injury, surgery, stroke, or other complex medical events, timely access to the right post-acute care setting is essential. These decisions are not simply administrative; care in the appropriate setting can affect whether a patient regains function, avoids complications, returns home safely, or receives the services needed to recover altogether.

The Coalition is also concerned by OIG's findings regarding third-party contractors and vendors involved in PA decisions. MAOs remain responsible for ensuring that their contractors, which may deploy algorithmic or artificial intelligence-supported tools in PA decision-making, comply with Medicare coverage rules. High denial overturn rates should prompt closer CMS oversight of whether these entities are applying Medicare standards accurately and enforcement with meaningful penalties when there are patterns of non-compliance.

The OIG reports underscore the need for better data, transparency, and stronger accountability. The Coalition urges the Centers for Medicare and Medicaid Services (CMS) to implement OIG's recommendations to collect detailed, request-level PA data—including standardized service type, contractor involvement, denial rationales, decision timelines, appeal outcomes, and information on continued-stay requests. CMS should make these data publicly available and also examine why denial and overturn rates vary so widely across plans and contractors and take corrective action, where appropriate.

The Coalition further urges OIG and CMS to conduct a similar review of MA practices affecting home health services. Home health providers report that even when care is approved, MA plans frequently authorize fewer visits than clinically appropriate and reimburse at rates significantly below traditional fee-for-service (FFS) Medicare. As a result, patients may be left without the full scope of services they need to recover safely at home.

MA plans are required to provide access to Medicare Part A and Part B services in a manner comparable to traditional FFS Medicare. The OIG reports make clear that stronger oversight, greater transparency, and more consistent enforcement are needed to ensure MA beneficiaries receive the post-acute care they are entitled to under Medicare, in the most clinically appropriate setting. Our groups collectively applaud the OIG's observation that, "as enrollment in Medicare Advantage continues to grow, so does the urgency and importance of ensuring that MAOs are delivering on the value that the Federal Government pays them to provide."

The PAC MA Coalition therefore stands ready to work with CMS, Congress, OIG, MA organizations, and other stakeholders to address PA, reduce unnecessary administrative burden to providers, ensure adequate payment, and protect timely access to medically necessary post-acute care.

The PAC MA Coalition renews its [request](#) for CMS to standardize post-acute care prior authorization procedures across MA plans. Greater consistency, compliance, and accountability are needed to ensure decisions reflect traditional Medicare FFS standards. Expedited PA is essential so beneficiaries receive timely, medically necessary services and avoid unnecessary delays in recovery."

About the PAC MA Coalition

Post-Acute Care (PAC) is made up of approximately 15,000 skilled nursing facilities (SNFs), 11,500 home health agencies (HHAs), 1,200 inpatient rehabilitation facilities (IRFs), and 370 long-term acute care hospitals (LTCHs), among other provider types.

The Post Acute Care Medicare Advantage (PAC MA) Coalition is comprised of LeadingAge, the American Health Care Association and National Center for Assisted Living (AHCA/NCAL), the American Medical Rehabilitation Providers Association (AMRPA), the National Alliance for Care at Home (the Alliance), the National Association of Long Term Hospitals (NALTH), and the Center for Medicare Advocacy. Together, the Coalition represents the interests of PAC providers and the Medicare beneficiaries who require their services.

The Coalition's objective is to ensure Medicare beneficiaries enrolled in MA and Special Needs Plans (SNPs) receive comparable and timely access to Medicare Part A and B services as their Traditional Medicare counterparts, while also ensuring the financial viability of providers who participate in MA networks through adequate payment and reduced administrative burden.