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DATA BRIEF

June 2026 | OEI-09-24-00330

The Three Largest Medicare Advantage Organizations Denied Requests for Long-Term Acute Care and Inpatient Rehabilitation at Some of the Highest Rates

HHS Office of Inspector General
HIGHLIGHTS

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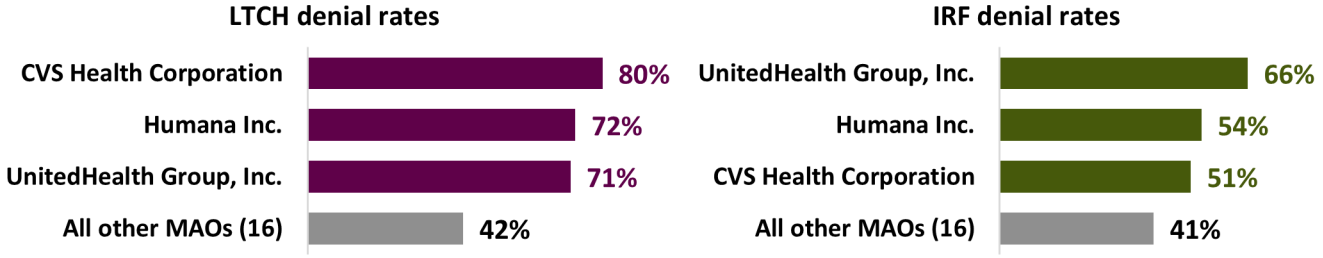
The Three Largest Medicare Advantage Organizations Denied Requests for Long-Term Acute Care and Inpatient Rehabilitation at Some of the Highest Rates

Why OIG Did This Review

- Previous OIG work raised concerns that Medicare Advantage organizations' (MAOs') use of prior authorization can in some cases result in denials and delays in access to needed care for enrollees. MAOs that inappropriately deny care are not delivering the full value that taxpayers pay them to provide.
- OIG identified denials of prior authorization requests for post-acute care after a hospital stay as a particular area of concern. This report shines new light on variation in denial and overturn rates of requests for admission to long-term care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs), which provide therapeutic and rehabilitative care to patients after an illness or injury.

What OIG Found

- Among the 19 MAOs in this review, the 3 largest MAOs by enrollment denied prior authorization requests for care in LTCHs and IRFs at higher rates than most of their peers in June 2024.



- When enrollees appealed, MAOs collectively overturned 36 percent of LTCH denials and 43 percent of IRF denials, indicating that some enrollees were initially denied medically necessary care. Some MAOs had much higher overturn rates than their peers. For example, IRF overturn rates ranged by MAO from 14 percent to 86 percent.
- In some cases, high denial rates were driven by contractors that denied prior authorization requests on behalf of the MAOs, many of which were later overturned on appeal by the MAO. This raises concerns about whether contractors are receiving appropriate training and oversight from MAOs.

What OIG Recommends

To efficiently identify and respond to concerning patterns of prior authorization denials, CMS should: (1) regularly collect request-level prior authorization data that include service type and contractor information and (2) assess reasons for the wide variation in LTCH and IRF denial and overturn rates across MAOs and contractors and take action as appropriate. CMS did not explicitly concur or nonconcur with either of our recommendations.

Primer: Medicare Advantage and Post-Acute Care

Medicare Advantage

People who are eligible for benefits under original Medicare may choose to receive their Medicare coverage through Medicare Advantage plans administered by Medicare Advantage organizations (MAOs). In 2024, 54 percent of people with Medicare (32.8 million people) were enrolled in Medicare Advantage, and the Centers for Medicare & Medicaid Services (CMS) paid MAOs an estimated $494 billion.[1, 2]

Medicare Advantage plans must cover at least the same services as original Medicare.[3] MAOs are expected to implement critical program controls to avoid unnecessary costs and ensure program integrity while at the same time ensuring that enrollees can get necessary and appropriate care. To do that, MAOs may impose additional administrative requirements, such as requiring prior authorization before certain services can be provided. For example, MAOs may require prior authorization for services with a history of improper payments in original Medicare, such as requests for inpatient rehabilitation.[4]

Under Medicare Advantage's payment model, MAOs are paid a risk-adjusted, capitated payment each month for each enrollee regardless of the number of services the enrollee receives.[5] A central concern about capitated payment models is the potential incentive for insurers to deny enrollees' access to services in an attempt to increase profits. Inappropriate denials of care can have serious impacts for enrollees' health, and MAOs that inappropriately deny care are not delivering the full value that taxpayers pay them to provide.

Facility-Based Post-Acute Care for Medicare Advantage Enrollees

Post-acute care facilities provide medical, therapeutic, and rehabilitative care to patients, typically after a qualifying stay in a general acute-care hospital, to help patients regain the ability to return to their home or community setting.[6] For patients who need post-acute care, the hospital care team typically helps to identify which post-acute care setting is appropriate for them. After considering patient needs and preferences, the hospital submits a request for admission to the selected facility.[7] The post-acute care facility then conducts its own assessment to determine whether the patient meets its admission criteria. Post-acute care facilities include long-term care hospitals (LTCHs),[8] inpatient rehabilitation facilities (IRFs),[9] and skilled nursing facilities (SNFs).[10, 11]

Long-term care hospitals (LTCHs) provide acute care to patients who need hospital-level care for extended periods of time. LTCHs provide specialized services such as respiratory therapy, head trauma treatment, and pain management.

Inpatient rehabilitation facilities (IRFs) provide intensive therapy and medical services in a hospital environment to patients with complex nursing, medical management, and rehabilitative needs.

Skilled nursing facilities (SNFs) provide short-term skilled nursing or therapy services to patients for rehabilitation following inpatient hospital stays, such as for joint replacement or stroke.

If a post-acute care facility approves a patient for admission, and the patient's MAO requires prior authorization for post-acute care, then the facility or the hospital care team must request authorization for the post-acute care stay from the MAO. The MAO reviews prior authorization requests to determine whether to approve or deny the request; this review can occur internally in the MAO, or the MAO may contract with another company to conduct the review.[12] If the MAO or its contractor denies the request for post-acute care, the patient or their care team can appeal the denial back to the MAO.[13]

Related Work

This report is part of a body of work that the Office of Inspector General (OIG) has conducted related to denials of care in managed care programs. This report also has a companion report, OEI-09-24-00331, which analyzes MAO data on prior authorization requests for SNF stays. In future work, OIG will conduct an in-depth review of a sample of case files to examine MAOs' processes for reviewing prior authorization requests for post-acute care.

In a 2022 report, OIG physician reviewers found that among the prior authorization requests (for all service types) that MAOs denied, 13 percent met Medicare coverage rules.[14] In other words, these services likely would have been approved if the patients had been enrolled in original Medicare rather than in Medicare Advantage. One of the prominent service types that was denied even though the requests met Medicare coverage rules was requests for post-acute care. Denying requests that meet Medicare coverage rules may prevent or delay enrollees from receiving medically necessary care and can burden providers.

In a 2018 report, OIG found that when enrollees and providers appealed denied requests between 2014 and 2016, MAOs overturned about 75 percent of their own prior authorization and payment denials.[15] This indicates that at least some of these denials were inappropriate or could have been avoided, given that ultimately the plans agreed to authorize the medically necessary services and make the payments. OIG also found that CMS cited more than half of audited Medicare Advantage contracts in 2015 for inappropriately denying prior authorization and payment requests.

OIG has also conducted work related to denials of care and payment in Medicaid managed care and Medicare Part D.[16, 17, 18, 19]

How OIG Did This Review

To calculate denial and appeal rates for LTCH and IRF admission requests, we collected data from the 19 largest MAO parent companies by enrollment about the prior authorization requests that they or their contractors processed in June 2024. To resolve any discrepancies in the data and to better understand the trends in our analysis, we followed up in writing with select MAOs. We also interviewed patient advocacy and industry organizations to hear their perspectives. The analysis in this report provides important insights about prior authorization patterns across companies and indicates opportunities for followup and potential action, but we cannot determine from this data analysis alone whether or how many of these denials were inappropriate.

The 19 MAOs in this study had 29.3 million people enrolled in their Medicare Advantage contracts in June 2024, which represented 86 percent of enrollment in the Medicare Advantage program at that time (see Appendix A).

FINDINGS

The three largest MAOs denied prior authorization requests for care in LTCHs and IRFs at higher rates than most of their peers

In June 2024, the 19 MAOs in this review denied almost two-thirds of requests for LTCH admission (approximately 2,100 of 3,200 requests) and denied more than half of requests for IRF admission (approximately 10,500 of 19,400 requests).

65% of LTCH requests were denied

54% of IRF requests were denied

Within these two post-acute care settings, denial rates varied among the 19 MAOs, with some MAOs denying requests at much higher rates than their peers (see Appendices B and C for MAO request volume and denial rates by setting).

Exhibit 1: CVS Health Corporation; Humana Inc.; and UnitedHealth Group, Inc., received the most requests for LTCH admission and had three of the five highest denial rates

MAO	LTCH requests June 2024	LTCH denial rate
CVS Health Corporation	393	80%
Highmark Health	63	73%
Humana Inc.	942	72%
UnitedHealth Group, Inc.	1,098	71%
Elevance Health, Inc.	211	63%
BCBS of Michigan Mutual Ins.	75	44%
The Cigna Group	103	33%
Centene Corporation	118	24%
UPMC Health System	72	8%

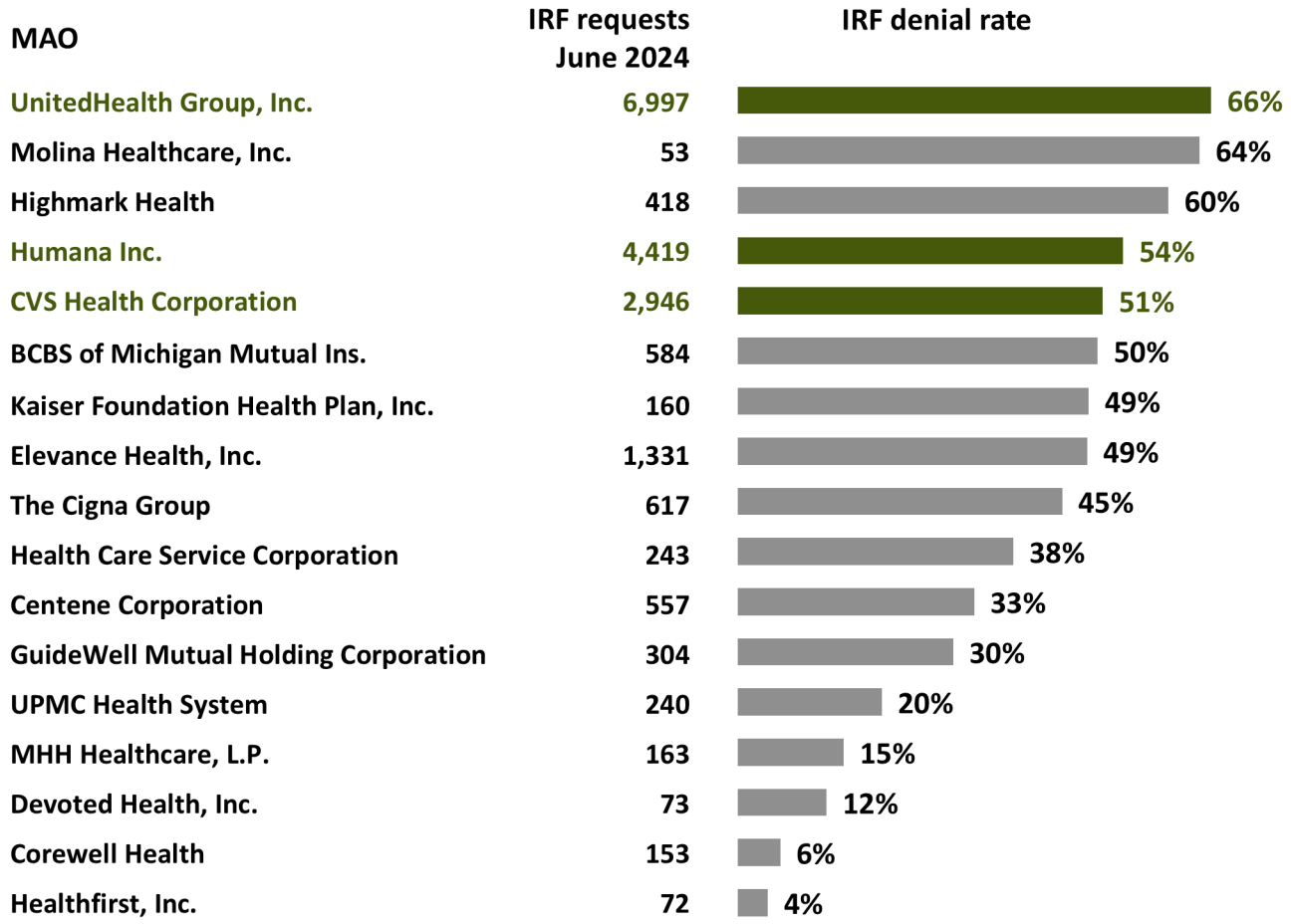
Source: OIG analysis of June 2024 LTCH prior authorization data for MAOs that received at least 50 LTCH requests.

Note: CVS Health Corporation is the parent company of Aetna.

The three largest MAOs by enrollment (UnitedHealth Group, Inc., Humana Inc.; and CVS Health Corporation) received the most requests for LTCH admission and denied them more than 70 percent of the time. Nearly 20 million people were enrolled in plans operated by these 3 companies.[20] (See Appendix A for information on MAO enrollment.) Highmark Health also denied more than 70 percent of requests for

LTCH admission, but it had a much lower enrollment and processed only 63 LTCH requests in June 2024.

Exhibit 2: UnitedHealth Group, Inc.; Humana Inc.; and CVS Health Corporation received the most requests for IRF admission and had three of the five highest denial rates



Source: OIG analysis of June 2024 IRF prior authorization data for MAOs that received at least 50 IRF requests.

UnitedHealth Group, Inc.; Humana Inc.; and CVS Health Corporation also received the most requests for IRF admission and had three of the highest denial rates, each denying more than 50 percent of requests for IRF admission. Molina Healthcare, Inc., and Highmark Health also denied more than 50 percent of IRF admission requests, but they received far fewer requests than the three largest MAOs.

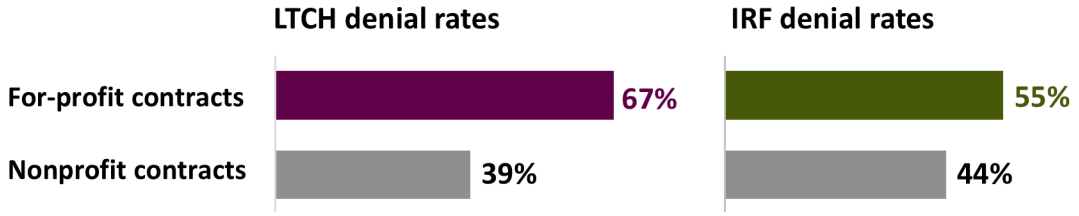
This analysis provides important insights about prior authorization patterns across companies and indicates opportunities for followup and potential action, but we cannot determine from this data analysis alone whether or how many of these denials were inappropriate. Although no specific denial rate is expected or correct, the wide variation in MAO denial rates for LTCH and IRF requests is concerning because it is unclear why some MAOs had denial rates that were much higher than their peers. Extremely high or low denial rates may indicate differences in MAO

policies or performance, such as how they interpret or apply coverage criteria. In future work, OIG will conduct an in-depth review of a sample of case files to examine MAOs' processes for reviewing prior authorization requests for post-acute care.[21]

Denial rates for LTCH and IRF admission were higher among for-profit MAO contracts than nonprofit MAO contracts

Differences in denial rates between for-profit and nonprofit MAO contracts suggest that financial incentives may be partially driving higher denial rates among some MAOs (see Appendix D for details). MAOs can operate for-profit contracts only, nonprofit contracts only, or both types of contracts. The three largest MAOs with some of the highest denial rates for LTCH and IRF admission—UnitedHealthcare, Inc.; Humana Inc.; and CVS Health Corporation—operated only for-profit Medicare Advantage contracts at the time of our review. (See Appendix A for the number of for-profit and nonprofit contracts operated by each MAO.)

Exhibit 3: For-profit MAO contracts denied LTCH and IRF admission requests at higher rates than nonprofit contracts



Source: OIG analysis of June 2024 MAO LTCH and IRF prior authorization data and 2024 contract tax status from CMS's Health Plan Management System.

Generally, LTCH and IRF care costs more than other post-acute care settings, such as SNFs or home health. Although information about what MAOs pay to different types of providers is not available, payment amounts in original Medicare can provide helpful context for the relative cost of care in each setting. Our companion report found that MAOs had lower denial rates of prior authorization requests for SNF admission than for LTCH or IRF admission.[22]

Exhibit 4: MAO payment amounts for LTCH and IRF stays are not available, but data from original Medicare show that they are more expensive than SNF stays or home health services

Post-acute care setting	Average cost in original Medicare, 2023
LTCHs	**$49,000**
IRFs	**$24,000**
SNFs	$16,000
Home health	$6,000

Sources: MedPAC, *A Data Book: Healthcare Spending and the Medicare Program,* July 2025. MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2025.[23, 24]

Some MAOs overturned LTCH and IRF denials at high rates upon appeal, raising concerns that some initial denials were inappropriate

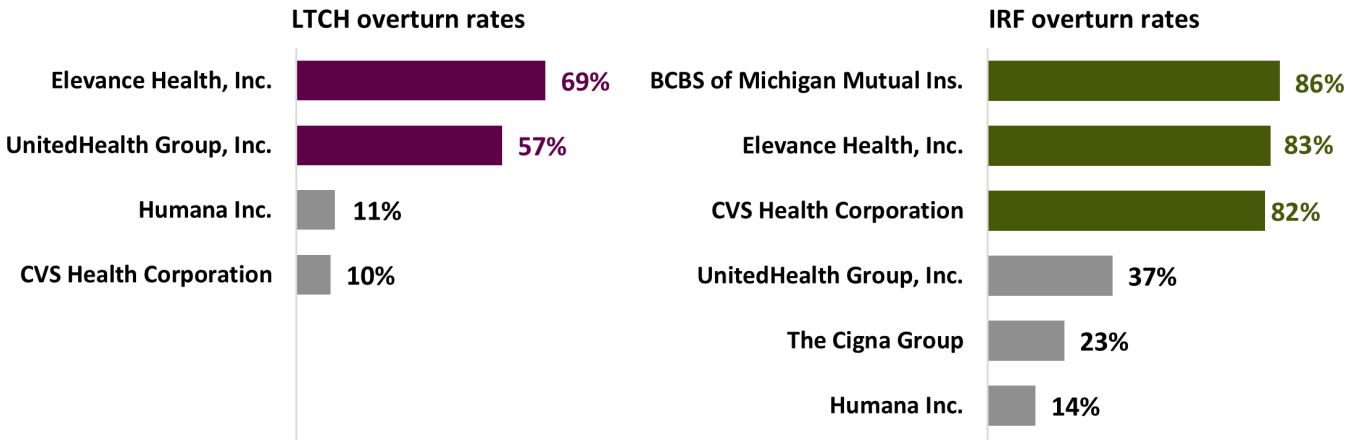
When enrollees appealed, MAOs overturned 36 percent of denials for LTCH admission (272 of 754 appeals) and 43 percent of denials for IRF admission (1,406 of 3,295 appeals).

36% of LTCH denials were overturned on appeal

43% of IRF denials were overturned on appeal

Some MAOs had much higher overturn rates than their peers (see Appendices B and C). Among MAOs that received at least 50 appeals in each setting, two overturned more than half of appealed LTCH denials and three overturned more than 80 percent of appealed IRF denials.

Exhibit 5: Several MAOs overturned a high proportion of LTCH and IRF denials upon appeal



Source: OIG analysis of June 2024 LTCH and IRF appeals data for MAOs that received at least 50 appeals in each setting.

Among the three largest MAOs, UnitedHealth Group, Inc., had the second-highest overturn rate for LTCH denials that were appealed—overturning 57 percent. For IRF denials that were appealed, CVS Health Corporation overturned 82 percent, far above the overall overturn rate of 43 percent. In contrast, Humana Inc. had relatively low overturn rates for both LTCH and IRF denials that were appealed. While Elevance Health, Inc., reviewed fewer cases than the three largest MAOs, it had some of the highest overturn rates for LTCH and IRF denials that were appealed.

Although overturned denials mean that the enrollee was ultimately approved to receive the requested care, each overturned denial represents a case in which the patient or their provider had to file an appeal and wait for a decision to access LTCH and IRF services covered by Medicare Advantage. This extra step may add

unnecessary complexity and administrative burden for enrollees, providers, and MAOs. High overturn rates may also indicate issues within the MAO's initial review process and an opportunity for improvement to issue the correct decision at the initial request.

Enrollees who appealed LTCH and IRF denials typically received a decision 5 to 6 days after their initial request, with some waiting much longer

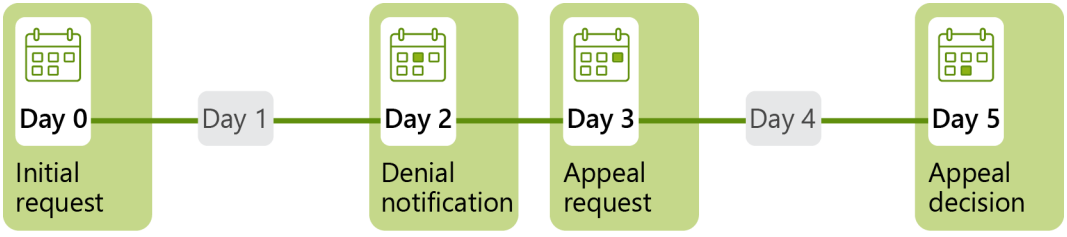
Given the relatively high rates of prior authorization denials for LTCH and IRF requests, the appeals process is an important safeguard to help ensure that patients have access to needed services. Enrollees and providers appealed around one-third of requests for LTCH and IRF admissions that MAOs denied (754 of 2,108 LTCH denials and 3,295 of 10,512 IRF denials). For the patients who did not appeal LTCH or IRF denials, they may have requested a lower level of care (e.g., SNF care or home health), paid for LTCH or IRF care out of pocket, or gone without post-acute care.

36% of LTCH denials were appealed

31% of IRF denials were appealed

For enrollees who appealed prior authorization denials for LTCH and IRF stays, the typical (i.e., median) wait time from the initial request date to the appeal decision date was 6 days for LTCH requests and 5 days for IRF requests in June 2024. A large number of enrollees waited even longer for an appeal decision. For example, 8 percent of IRF appeals and 16 percent of LTCH appeals took 10 days or more to receive a decision.

Exhibit 6: Patients who appealed IRF denials typically received a decision 5 days after their initial request



Source: OIG analysis of MAO IRF appeals data for June 2024 denials. The timeline shows the median number of days between each step for denials that were appealed.

Enrollees who are requesting post-acute care are usually receiving care in an acute-care hospital while they wait for the MAO's decision. However, delays in accessing needed rehabilitation such as physical therapy and occupational therapy can have

significant and long-term negative health effects on patients. For example, longer wait times for transfer to an IRF following a brain injury is associated with reduced improvement in functional status and higher care needs over time.[25] Spending extra days in an acute hospital setting can also increase a patient's risk of hospital-acquired patient complications (e.g., health care-associated infections and falls).[26] Unnecessary or "avoidable" days spent in a hospital can also mean a significant financial cost to hospitals that is not separately reimbursable.[27]

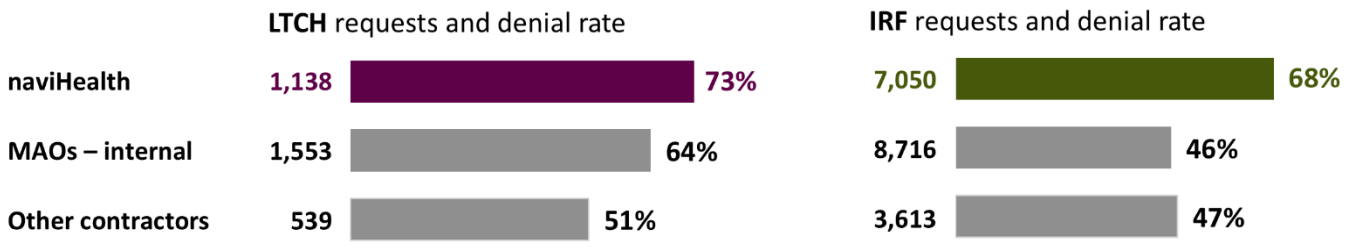
Some contractors were more likely to deny LTCH and IRF requests than MAOs that processed requests internally; many contractor denials were later overturned by MAOs

MAOs can choose to process LTCH and IRF requests internally or can hire contractors to process the requests for them.[28] In June 2024 for the 19 MAOs in our review, around half of LTCH and IRF requests were processed by contractors and half were processed by MAOs internally. Some contractors processed only a handful of requests for a single MAO while others processed thousands of requests across multiple MAOs.

The MAO contractor naviHealth denied LTCH and IRF requests at higher rates than MAOs and other contractors

The contractor naviHealth (a subsidiary of the MAO UnitedHealth Group, Inc.[29]) processed more than one-third of all LTCH and IRF requests submitted to the 19 MAOs in our review in June 2024. Most of the LTCH and IRF requests that naviHealth reviewed (81 percent) were for the MAO UnitedHealth Group, Inc., but naviHealth also processed requests for BCBS of Michigan Mutual Insurance Co., Highmark Health, and Humana Inc.

Exhibit 7: For both LTCH and IRF requests, the MAO contractor naviHealth denied requests at higher rates than other contractors and MAOs that processed requests internally



Source: OIG analysis of June 2024 MAO LTCH and IRF prior authorization data.

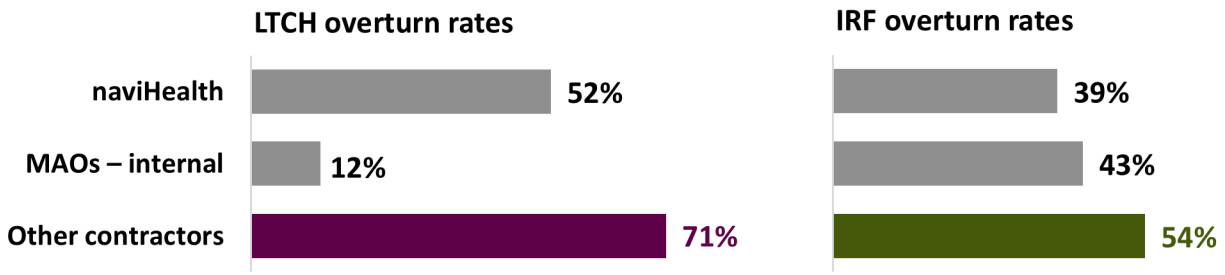
For both LTCHs and IRFs, naviHealth denied requests for admission at higher rates than requests that were reviewed internally by MAOs or reviewed by other MAO contractors. As found in our companion report, naviHealth also denied requests for admission to SNFs at higher rates than MAOs and other contractors.[30] The

contractor Carelon also had higher LTCH and IRF denial rates than MAOs that reviewed requests internally, but it processed far fewer requests than naviHealth (see Appendix E for denial and overturn rates by contractor). Large variation in denial rates between contractors and MAOs that review requests internally raise concerns about whether contractors are receiving appropriate training, guidance, and oversight from MAOs on how to assess requests.

MAOs overturned denials issued by contractors at high rates upon appeal

Although many MAOs used contractors to review initial prior authorization requests, they almost always reviewed any appeals internally. In general, denials from contractors were more likely to be overturned by MAOs upon appeal compared to denials originally issued by the MAOs themselves, particularly for LTCH appeals.

Exhibit 8: Denials issued by MAO contractors were more likely to be overturned upon appeal than denials issued by MAOs



Source: OIG analysis of June 2024 MAO LTCH and IRF appeals data.

Among LTCH appeals, denials issued by both naviHealth and other contractors were overturned at much higher rates than denials that MAOs reviewed internally. Among IRF appeals, denials issued by contractors other than naviHealth were overturned at higher rates than denials issued by naviHealth or MAOs. One reason for the higher overturn rates of denials issued by contractors may be differences in policies or procedures between the parent company and its contractor, or differences in interpretation of CMS coverage rules.

At the time of our review, CMS did not regularly collect prior authorization data that included standardized service types or contractor names

At the time of our review, CMS collected prior authorization data through two oversight efforts but did not regularly collect detailed, request-level prior authorization data from all MAOs. Detailed, request-level prior authorization data may be used to identify and analyze variation in denial and overturn rates by service type and among MAOs and contractors, such as in the findings above.

The two ways in which CMS collected prior authorization data had limitations. First, CMS collected aggregate prior authorization data from all MAOs as part of its Part C annual reporting requirements. However, as of the 2025 reporting year, CMS did not require MAOs to report information about the service types requested (e.g., requests for LTCH or IRF admission) or the contractors associated with those data.[31] Second, CMS collected request-level prior authorization data as part of its program audits. However, these data were collected for each MAO only for the year that particular MAO was audited, the service type variables were not standardized, and the timeframes for the data were limited.[32]

In September 2025, CMS received approval from the Office of Management and Budget to collect request-level prior authorization and appeals data from MAOs quarterly.[33] In December 2025, CMS solicited MAOs to volunteer for a data collection pilot and published the draft requirements for the data that it will be collecting.[34] The prior authorization data that CMS plans to collect do not include a standardized service type variable for all service types or the name of the contractor that processed the request (if applicable).[35]

CONCLUSION AND RECOMMENDATIONS

More than half of people with Medicare were enrolled in Medicare Advantage in 2024, and MAOs received an estimated $494 billion to cover at least the same services as original Medicare for these enrollees. MAOs are expected to implement critical program controls to avoid unnecessary costs and ensure program integrity while at the same time ensuring that enrollees can get necessary and appropriate care. However, our findings show patterns of denials for LTCH and IRF care that raise concerns.

The high concentration of enrollees in a few large MAOs, and the use of contractors to process prior authorization requests, means that the policies and performance of a few companies can impact care for millions of people. Our findings demonstrate that enrollees in the three largest MAOs faced higher denial rates for LTCH and IRF admission requests compared to enrollees in smaller MAOs, and that some contractors also had high denial rates. We identified similar concerns in our companion report on prior authorization requests for skilled nursing care in Medicare Advantage, OEI-09-24-00331. The wide variation in denial rates and high overturn rates among some MAOs raise concerns that some enrollees may not be receiving services that MAOs are required to provide.

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.

Therefore, we recommend that CMS:

Regularly collect request-level prior authorization data that include standardized service type and contractor information

Given OIG's body of work that has raised concerns about enrollee access to care in Medicare Advantage, including the concerns raised in this report, CMS should collect more comprehensive data in order to efficiently and effectively identify MAOs with problematic patterns of denials and take action as appropriate.

Specifically, CMS should regularly collect request-level prior authorization data with standardized, predefined service type fields that account for all service types. For example, as currently written, the draft data collection requirements do not include a standardized field to identify post-acute care admission to LTCHs, IRFs, or SNFs. To identify appropriate service type variables related to these post-acute care admissions, CMS could engage with MAOs to determine what variables are already available in their systems or are feasible to implement. CMS could also consider providing MAOs with a list of predefined service type categories that MAOs must use to categorize prior authorization requests.

Further, given this report's findings that the MAO contractor naviHealth denied requests for LTCH and IRF admission at higher rates than other contractors and MAOs, CMS should also collect data on which contractors are processing prior authorization requests. This would allow CMS to monitor contractors' denial rates across MAOs and take action to resolve problems as needed.

Assess reasons for the wide variation in LTCH and IRF denial and overturn rates across MAOs and contractors and take action as appropriate

CMS should identify the reasons for the wide variation in prior authorization denials and overturns for LTCH and IRF admissions and, if needed, take appropriate steps to address any problematic reasons. Variation in denial rates could indicate differences in program integrity efforts or misinterpretation or misapplication of CMS coverage rules. Extremely high rates may indicate inappropriate denials.

For example, CMS could engage with the MAOs that we identified with high denial rates for LTCH and/or IRF admission to determine whether they are meeting program requirements and take corrective action as appropriate. CMS could also engage with MAOs that employ contractors with high denial rates and/or overturn rates to determine whether the contractors are receiving appropriate training, guidance, and oversight from MAOs to comply with Medicare coverage rules.

AGENCY COMMENTS AND OIG RESPONSE

CMS did not explicitly concur or nonconcur with either of our recommendations. CMS stated that it uses several oversight tools, including annual audits, to ensure that the Medicare Advantage program provides adequate health care access to enrollees.

Regarding our first recommendation—to regularly collect request-level prior authorization data that include standardized service type and contractor information—CMS stated that it has launched a Medicare Advantage data collection pilot. Plans that have volunteered to join the pilot will report data on all service-level determinations, including service types and whether a third-party vendor (i.e., contractor) participated in the review. CMS shared its intent to gather lessons from this pilot to inform its next steps. As we note in our recommendation, the pilot's data collection requirements do not include standardized service type data for post-acute care admissions to LTCHs, IRFs and SNFs. They also do not include the name of any contractors involved in the review. As CMS develops its next steps, we recommend that CMS improve its data collection in these ways, among other lessons it may learn from the pilot.

Regarding our second recommendation—to assess reasons for the wide variation in LTCH and IRF denial and overturn rates across MAOs and contractors and take action as appropriate—CMS stated that it focuses its audits on specific areas of concern, such as evaluating individual medical necessity decisions for service types with a high rate of denial. However, CMS did not indicate whether and how it would target LTCH or IRF denials in future audits or other oversight efforts. We ask that CMS include any specific plans or actions to assess rates of LTCH and IRF denials in its Final Management Decision.

For the full text of CMS's comments, see Appendix G.

METHODOLOGY

MAO Selection

To select the MAOs for this review, we used CMS Part C (i.e., Medicare Advantage) enrollment data to identify the largest MAO parent companies by enrollment. We selected the 19 parent companies that had at least 200,000 people enrolled in any Medicare Advantage contract in June 2024. These 19 parent companies operated contracts in 55 States and territories and covered 29.3 million people (see Appendix A). The companies covered approximately 86 percent of total Medicare Advantage enrollment in June 2024.

Data Collection

From each of the 19 selected MAOs, we collected a list of all prior authorization requests for admission to LTCHs and IRFs that the MAOs or their contractors processed during June 2024. For each prior authorization request, the MAOs provided detailed information, including:

- Enrollee identification numbers for enrollees who requested the service
- An open text description of the service requested
- A service type label (LTCH or IRF)
- The outcome of the initial request (approved or denied)
- The name of the MAO contractor that processed the request (if applicable)
- Whether the request was appealed and the appeal outcome
- Key dates (e.g., date of request, initial decision, appeal)

Where appropriate, we followed up with MAOs to resolve discrepancies in the submitted data.

In addition to collecting data from MAOs, we also analyzed data from the Medicare Enrollment Database, CMS's Health Plan Management System, and CMS's Minimum Data Set.

Analysis

Denial rates. We calculated the number and rate at which the selected MAOs denied prior authorization requests for LTCH and IRF admissions in June 2024 (see Appendices B and C). First, we summed all denials by setting across the 19 MAOs. To calculate the denial rates, we divided the total number of denials for each setting by the total number of prior authorization decisions that MAOs approved or

denied for the setting in June 2024.[36] We also calculated these rates by MAO to examine the distribution of rates across MAOs and to identify MAOs with particularly high rates. For the overall and MAO-level analyses, we included both requests processed internally by the MAOs and requests submitted to the MAOs that were processed by their contractor(s), if applicable. We calculated denial rates by setting and MAO for MAOs that processed at least 50 requests in a given setting (see Appendices B and C).

Tax status. To examine denial rates by tax status for each setting, we used data from CMS's Health Plan Management system to categorize contracts as for-profit or nonprofit/not-for-profit and then determined differences in denial rates (see Appendix D).

Appeals. To calculate the appeal rate for each setting, we divided the total number of appeals by the total number of initial denials issued across all MAOs. To calculate the overturn rates, we summed the total number of approved appeal decisions and divided by the total number of approved or denied appeal decisions. We calculated overturn rates by setting and MAO for MAOs that processed at least 50 appeals in a given setting (see Appendices B and C).

Timelines. To examine the typical timelines for requests for each setting, we used the following date fields: initial request date, initial request decision date, appeal date (if applicable), and appeal decision date (if applicable). Because outliers can affect the average (mean), we used the median (middle) number of days to represent the typical wait time between dates.

MAO contractors. To examine the denial and appeal outcome rates by MAO contractor for each setting, we calculated the rates by contractor across any MAO that they processed requests for. We compared the contractor rates with the rates for requests that were processed internally by MAOs.

Nursing home resident analysis. To examine the IRF and LTCH admission denial rate for nursing home residents, we used 2024 Minimum Data Set assessment data for the enrollees in our population. We followed the methods described in CMS's *MDS 3.0 Quality Measures User's Manual* to group assessments into episodes and to identify nursing home residents.[37] We identified nursing home residents as those with a "long-stay" episode (i.e., where the cumulative length of time in the facility for that episode was longer than or equal to 101 days). To account for patients who may have left nursing homes for extended hospitalization, we included patients with long-stays that ended up to 2 months before our June 2024 timeframe (i.e., long-stays that ended after April 1, 2024). We calculated denial rates for enrollees who were classified as long-stay and compared that rate to the denial rate for all other enrollees. We did not see notable differences in denial rates by nursing home residency for IRF and LTCH settings (see Appendix F).

Dual eligibility analysis. To examine any differences in denial rates by dually eligible enrollees versus Medicare Advantage-only enrollees, we used data from the

Medicare Enrollment Database to categorize enrollees by whether they were dually eligible for Medicare and Medicaid. We did not see notable differences in denial rates by dual eligibility for IRF and LTCH settings (see Appendix F).

CMS data collection. To examine CMS's current and planned collection of prior authorization data, we reviewed information about the annual Part C reporting requirements, CMS's Medicare Part C Program Audit Protocols, and CMS's "Draft Technical Specifications for Service Level Data Collection for Initial Determinations and Appeals."

Limitations

This report analyzed prior authorization data provided by the selected MAOs. We followed up with MAOs to resolve discrepancies in the submitted data, but we did not review medical or administrative records to independently verify the accuracy of the data.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued in 2020 by the Council of the Inspectors General on Integrity and Efficiency.

APPENDICES

Appendix A: Enrollment in the Sampled MAOs, June 2024

The 19 MAOs included in this review enrolled between 219,000 and 9.5 million people in June 2024. Service areas for these MAOs covered all 50 States, the District of Columbia, and 4 territories (Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands).

MAO Parent Organization	Enrollment	Number of States and/or Territories in Service Area	Number of Nonprofit Contracts	Number of For-Profit Contracts
UnitedHealth Group, Inc.	9,489,175	55	0	64
Humana Inc.	6,167,833	55	0	42
CVS Health Corporation	4,275,902	55	0	41
Elevance Health, Inc.	2,029,692	55	1	41
Kaiser Foundation Health Plan, Inc.	1,908,557	9	7	1
Centene Corporation	1,140,398	37	1	85
BCBS of Michigan Mutual Ins. Co.	709,396	55	2	4
The Cigna Group	593,784	55	0	14
Highmark Health	421,249	55	7	0
GuideWell Mutual Holding Corporation	333,565	52	1	5
Healthfirst, Inc.	297,333	51	3	1
MHH Healthcare, L.P.	290,618	2	0	2
SCAN Group	277,975	5	6	0
Molina Healthcare, Inc.	253,749	16	0	18
Corewell Health	249,561	51	3	0
Aware Integrated, Inc.	227,548	55	2	0
Health Care Service Corporation	224,292	55	4	5
Devoted Health, Inc.	223,423	13	0	24
UPMC Health System	219,213	54	2	2
Total	**29,333,263**	**-**	**39**	**349**

Source: OIG analysis of CMS Medicare Advantage contract and enrollment data for June 2024.

Appendix B: Volumes and Rates of LTCH Prior Authorization Requests and Appeals by MAO, June 2024

MAO	Initial Approvals	Initial Denials	Denial Rate	Appeals Overturned	Appeals Upheld	Overturn Rate
Aware Integrated, Inc.	7	1	-	1	0	-
BCBS of Michigan Mutual Ins. Co.	42	33	**44.0%**	14	1	-
Centene Corporation	90	28	**23.7%**	5	0	-
The Cigna Group	69	34	**33.0%**	5	5	-
Corewell Health	22	0	-	0	0	-
CVS Health Corporation	80	313	**79.6%**	11	104	**9.6%**
Devoted Health, Inc.	3	21	-	4	6	-
Elevance Health, Inc.	79	132	**62.6%**	36	16	**69.2%**
GuideWell Mutual Holding Corporation	20	14	-	4	1	-
Health Care Service Corporation	22	6	-	0	1	-
Healthfirst, Inc.	5	2	-	1	0	-
Highmark Health	17	46	**73.0%**	2	10	-
Humana Inc.	261	681	**72.3%**	26	216	**10.7%**
Kaiser Foundation Health Plan, Inc.	8	1	-	0	0	-
MHH Healthcare, L.P.	0	0	-	0	0	-
Molina Healthcare, Inc.	11	9	-	0	0	-
SCAN Group	1	2	-	0	0	-
UnitedHealth Group, Inc.	319	779	**70.9%**	162	121	**57.2%**
UPMC Health System	66	6	**8.3%**	1	1	-
Total	**1,122**	**2,108**	**65.3%**	**272**	**482**	**36.1%**

Source: OIG analysis of June 2024 MAO LTCH prior authorization and appeals data.

Note: LTCH prior authorization denial rates were calculated only for MAOs that received at least 50 LTCH requests; overturn rates were calculated only for MAOs that received at least 50 LTCH appeals.

Appendix C: Volumes and Rates of IRF Prior Authorization Requests and Appeals by MAO, June 2024

MAO	Initial Approvals	Initial Denials	Denial Rate	Appeals Overturned	Appeals Upheld	Overturn Rate
Aware Integrated, Inc.	28	9	-	0	0	-
BCBS of Michigan Mutual Ins. Co.	292	292	**50.0%**	115	19	**85.8%**
Centene Corporation	374	183	**32.9%**	42	1	-
The Cigna Group	339	278	**45.1%**	16	55	**22.5%**
Corewell Health	144	9	**5.9%**	0	1	-
CVS Health Corporation	1,452	1,494	**50.7%**	341	77	**81.6%**
Devoted Health, Inc.	64	9	**12.3%**	1	3	-
Elevance Health, Inc.	685	646	**48.5%**	147	30	**83.1%**
GuideWell Mutual Holding Corporation	213	91	**29.9%**	20	14	-
Health Care Service Corporation	150	93	**38.3%**	3	19	-
Healthfirst, Inc.	69	3	**4.2%**	1	0	-
Highmark Health	168	250	**59.8%**	10	33	-
Humana Inc.	2,053	2,366	**53.5%**	95	578	**14.1%**
Kaiser Foundation Health Plan, Inc.	82	78	**48.8%**	3	6	-
MHH Healthcare, L.P.	139	24	**14.7%**	1	0	-
Molina Healthcare, Inc.	19	34	**64.2%**	1	3	-
SCAN Group	9	3	-	0	0	-
UnitedHealth Group, Inc.	2,395	4,602	**65.8%**	606	1,046	**36.7%**
UPMC Health System	192	48	**20.0%**	4	4	-
Total	**8,867**	**10,512**	**54.2%**	**1,406**	**1,889**	**42.7%**

Source: OIG analysis of June 2024 MAO IRF prior authorization and appeals data.

Note: IRF prior authorization denial rates were calculated only for MAOs that received at least 50 IRF requests; overturn rates were calculated only for MAOs that received at least 50 IRF appeals.

Appendix D: Volumes and Rates of LTCH and IRF Prior Authorization Requests by Profit Status, June 2024

	For-Profit Contracts			Nonprofit or Not-for-Profit Contracts		
Setting	**Initial Approvals**	**Initial Denials**	**Denial Rate**	**Initial Approvals**	**Initial Denials**	**Denial Rate**
LTCH	986	2,022	**67.2%**	136	86	**38.7%**
IRF	7,958	9,802	**55.2%**	909	710	**43.9%**

Source: OIG analysis of June 2024 MAO LTCH and IRF prior authorization data and MAO contract tax status from CMS's Health Plan Management System.

Appendix E: Volumes and Rates of Prior Authorization Request and Appeal Outcomes by Contractor, June 2024

LTCH Requests

Reviewing Entity	Initial Approvals	Initial Denials	Denial Rate	Appeals Overturned by MAOs	Appeals Upheld by MAOs	Overturn Rate
naviHealth	302	836	**73.5%**	161	151	**51.6%**
MAOs – internal	556	997	**64.2%**	41	303	**11.9%**
Other contractors (excluding naviHealth)	264	275	**51.0%**	70	28	**71.4%**
Carelon	*48*	*112*	*70.0%*	*34*	*14*	-
WellMed	*37*	*71*	*65.7%*	*19*	*5*	-
CareCentrix	*49*	*36*	*42.4%*	*9*	*1*	-
EviCore	*72*	*34*	*32.1%*	*6*	*5*	-
Contractors not listed above	*58*	*22*	*27.5%*	*2*	*3*	-

Source: OIG analysis of June 2024 LTCH prior authorization data. Overturn rates were calculated only for entities that received at least 50 appeals.

IRF Requests

Reviewing Entity	Initial Approvals	Initial Denials	Denial Rate	Appeals Overturned by MAOs	Appeals Upheld by MAOs	Overturn Rate
naviHealth	2,261	4,789	**67.9%**	665	1,047	**38.8%**
MAOs – internal	4,706	4,010	**46.0%**	461	604	**43.3%**
Other contractors (excluding naviHealth)	1,900	1,713	**47.4%**	280	238	**54.1%**
Carelon	*433*	*570*	*56.8%*	*138*	*25*	*84.7%*
WellMed	*565*	*384*	*40.5%*	*58*	*122*	*32.2%*
CareCentrix	*208*	*225*	*52.0%*	*51*	*15*	*77.3%*
EviCore	*364*	*293*	*44.6%*	*16*	*55*	*22.5%*
Contractors not listed above	*330*	*241*	*42.2%*	*17*	*21*	-

Source: OIG analysis of June 2024 IRF prior authorization data. Overturn rates were calculated only for entities that received at least 50 appeals.

Appendix F: Volumes and Rates of Prior Authorization Requests and Appeals by Demographic Characteristics, June 2024

LTCH Requests

Enrollee Characteristic	Initial Approvals	Initial Denials	Denial Rate
Nursing home residents	26	52	**66.7%**
All other enrollees	1,096	2,056	**65.2%**
Enrollees eligible for both Medicare and Medicaid ("dually eligible")	438	858	**66.2%**
Medicare Advantage-only enrollees	684	1,250	**64.6%**

Source: OIG analysis of June 2024 LTCH prior authorization data, demographic data from the Medicare Enrollment Database, and 2024 data on enrollee nursing home stays from the Minimum Data Set.

IRF Requests

Enrollee Characteristic	Initial Approvals	Initial Denials	Denial Rate
Nursing home residents	15	22	-
All other enrollees	8,852	10,490	**54.2%**
Dually eligible	2,060	2,524	**55.1%**
Medicare Advantage-only enrollees	6,807	7,988	**54.0%**

Source: OIG analysis of June 2024 IRF prior authorization data, demographic data from the Medicare Enrollment Database, and 2024 data on enrollee nursing home stays from the Minimum Data Set.

Appendix G: Agency Comments

CMS's official comments begin on the next page.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: May 4, 2026

TO: Megan Tinker
Chief of Staff

FROM: Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: The Three Largest Medicare Advantage Organizations Denied Requests for Long-Term Acute Care and Inpatient Rehabilitation at Some of the Highest Rates, OEI-09-24-00330

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to program integrity and its enforcement and oversight of the Medicare Advantage (MA) program.

MA plans are Medicare-approved managed care plans offered by Medicare Advantage Organizations (MAOs), which are private companies, as an alternative to Original Medicare. MAOs must generally cover the same benefits as Original Medicare, such as stays in Long-Term Care Hospitals (LTCHs) and Inpatient Rehabilitation Facilities (IRFs). However, as part of the managed care structure, MAOs may apply internal coverage policies that are no more restrictive than original Medicare's national and local coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature to make medical necessity determinations, as permitted in 42 C.F.R. § 422.101(b)(6).

For Medicare basic benefits, MAOs must make medical necessity determinations in accordance with all medical necessity determination requirements, outlined at 42 C.F.R. § 422.101(c)(1); based on the circumstances of each specific individual, including the patient's medical history, physician recommendations, and clinical notes; and in line with all fully established Traditional Medicare coverage criteria. This includes established criteria in applicable Medicare statutes, regulations, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs).

CMS uses several oversight tools to ensure that the MA program provides adequate health care access to enrollees. For example, as part of its oversight strategy, CMS conducts audits of a subset of MAOs each year to assess compliance with the terms of their contracts with CMS, in particular the requirements associated with access to medical services, drugs, and other enrollee protections required by Medicare. The audit program operates on a continuous, rotating basis to promote broad coverage over time; therefore, the MAOs selected for audit may vary annually, and not all MAOs are audited in a given year. This approach allows CMS to be responsive and direct its audits to areas of identified concern, such as service types with a high rate of denial. As designed, these audits extend beyond data analysis by

evaluating whether MAOs applied clinical criteria in accordance with CMS rules and appropriately adjudicated those determinations. In cases where denied claims are overturned on appeal, CMS notes the initial denial may still have been warranted if it stemmed from incomplete documentation that was subsequently provided during the appeal. Following an audit, CMS notifies the plan of identified noncompliance, such as when the plan's denial of coverage does not align with CMS rules and may prevent enrollees from accessing care. MAOs are then required to submit corrective action plans when remediation is necessary to strengthen internal controls, prevent recurrence of noncompliance, and/or address any impact to enrollees. Further, plans that are found to have significant or repeated violations may be subject to penalties, such as Civil Monetary Penalties and intermediate sanctions (suspension of payment, enrollment, and/or marketing activities). In recent years, CMS has increased the transparency of noncompliance with CMS requirements publishing Compliance and Enforcement actions on the CMS.gov website[1] and developing a publicly available annual report with business practices MAOs can adopt to continue improving performance.

Recently, CMS has developed a data collection pilot called the Service Level Data Collection for Initial Determination and Appeals[2]. CMS implemented this new data collection in February 2026 and will collect all service-level determinations, including prior authorization information across all settings, including IRFs and LTCHs. Pilot plans will report whether a third-party vendor participated, in any capacity, in the determination, review, or decision-making related to determination reviews and decision-making processes (which include prior authorization requests). This data will permit CMS to analyze the relationship between denial rates and whether a third-party vendor was involved with the plans participating in the pilot. This data will also allow CMS to identify and analyze prior authorization decisions by service type for pilot participants and whether there was vendor involvement.

OIG's recommendations and CMS's responses are below.

OIG Recommendation

CMS should regularly collect request-level prior authorization data that include standardized service type and contractor information.

CMS Response

As mentioned above, CMS has launched an MA data collection pilot for plans that have volunteered to join. Among other data, pilot participants will be reporting service-level prior authorization data, including service types, across all settings. Pilot participants will also report information related to whether a third-party vendor was involved in the determination review and decision-making process. CMS will analyze pilot denial rates by a number of characteristics, including by service and involvement of a third-party vendor. CMS looks forward to gathering lessons learned from conducting this pilot, which will inform our next steps.

OIG Recommendation

CMS should assess reasons for the wide variation in LTCH and IRF denial and overturn rates across MAOs and contractors and take action as appropriate.

[1] Please see: https://www.cms.gov/medicare/audits-compliance/part-c-d/part-c-and-part-d-enforcement-actions

[2] Please see December HPMS memo here: https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-3-december-15-19.

CMS Response

As mentioned above, CMS's broad oversight strategy includes auditing a varying selection of MAOs each year to assess their compliance with contract terms, particularly regarding access to medical services, drugs, and other enrollee protections required by Medicare. CMS also focuses its audits on specific areas of concern, such as evaluating individual medical necessity decisions for service types with a high rate of denial and will continue to do so. When significant or repeated noncompliance is identified, CMS has a well-established record of implementing appropriate compliance and enforcement actions to address inappropriate delays or denials of medically necessary care.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

ENDNOTES

[1] Meredith Freed et al., "Medicare Advantage in 2024: Enrollment Update and Key Trends" (Aug. 8, 2024). Accessed on Dec. 1, 2025.

[2] MedPAC, *Report to the Congress: Medicare Payment Policy,* Chapter 11: The Medicare Advantage program: Status report, March 2025. Accessed on Oct. 20, 2025.

[3] At a minimum, MAOs must cover the same services as in original Medicare, although they may also offer supplemental benefits. 42 CFR §§ 422.101(a) and (b); 422.102. MAOs are not responsible for paying hospice care costs for beneficiaries; original Medicare pays these costs.

[4] HHS, *2024 Medicare Fee-for-Service Supplemental Improper Payment Data*. Accessed on Aug. 18, 2025.

[5] 42 CFR § 422.304.

[6] American Hospital Association, "Fact Sheet: Post-Acute Care" (July 2019). Accessed on Dec. 1, 2025.

[7] OIG interviews with post-acute care providers, industry groups, and hospitals, 2024.

[8] CMS, "What are Long-Term Care Hospitals?" (June 2019). Accessed on Dec. 1, 2025.

[9] CMS, "Inpatient Rehabilitation Hospitals & Inpatient Rehabilitation Units" (November 2025). Accessed on Jan. 6, 2026.

[10] MedPAC, *Report to the Congress: Medicare Payment Policy,* Chapter 8: Skilled nursing facility services, March 2018. Accessed on Jan. 6, 2026.

[11] Although there are some circumstances in which a patient may receive care at an LTCH, IRF, or SNF without a preceding acute-care hospital stay, for the purposes of this study, we refer to these facilities collectively as "post-acute care facilities."

[12] MAOs are responsible for complying with coverage requirements even if they contract with another company to conduct reviews. 42 CFR § 422.504(i)(1).

[13] 42 CFR § 422.578.

[14] OIG, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care* (OEI-09-18-00260), Apr. 27, 2022.

[15] OIG, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials* (OEI-09-16-00410), Sept. 25, 2018.

[16] OIG, *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care* (OEI-09-19-00350), July 17, 2023.

[17] OIG, *Keystone First Should Improve Its Procedures for Reviewing Service Requests That Require Prior Authorization* (A-03-20-00201), Dec. 20, 2022.

[18] OIG, *New York Did Not Ensure That a Managed Care Organization Complied With Requirements for Denying Prior Authorization Requests* (A-02-21-01016), Sept. 18, 2023.

[19] OIG, *Some Medicare Part D Beneficiaries Face Avoidable Extra Steps That Can Delay or Prevent Access to Prescribed Drugs* (OEI-09-16-00411), Sept. 19, 2019.

[20] CMS, Medicare Advantage and Part D Enrollment Data, Monthly Enrollment by Contract, June 2024. Accessed on Jan. 30, 2025.

[21] OIG, *Medicare Advantage Organization's Use of Prior Authorization for Post-Acute Care*, OEI-09-24-00332, expected to be issued in FY 2027.

[22] OIG, *Medicare Advantage Organizations Overturned Nearly All Appealed Prior Authorization Denials for Skilled Nursing Facility Admission, Raising Concerns About Initial Denials*, OEI-09-24-00331, June 11, 2026.

[23] MedPAC, *A Data Book: Healthcare Spending and the Medicare Program,* July 2025. Accessed on July 16, 2025. For average payment per LTCH stay, see p. 126.

[24] MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2025. Accessed on July 16, 2025. For average payment per IRF stay, see Chapter 8: Inpatient rehabilitation facility services, p. 249. Original Medicare spent $9.6 billion for 404,000 IRF stays in 2023, for an approximate average of $24,00 per stay. For average payment per SNF stay, see Chapter 6: Skilled nursing facility services, p. 188. Original Medicare paid $25 billion for 1,583,000 SNF stays in 2023, for an approximate average of $16,000 per stay. For average payment for home health services, see Chapter 7: Home health care services, p. 232.

[25] Lloyd Bradley and Sally Wheelwrite, "The impact of delays in transfer to specialist rehabilitation on outcomes in patients with acquired brain injury," *Clinical Rehabilitation*, vol. 38, no. 11 (Sept. 25, 2024), pp. 1552–1558. Accessed on July 10, 2025.

[26] Agency for Healthcare Research and Quality, *Interventions To Decrease Hospital Length of Stay* (AHRQ Pub. No. 21-EHC015), Sept. 2021. Accessed on Jan. 6, 2026.

[27] American Hospital Association, "Issue Brief: Patients and Providers Faced with Increasing Delays in Timely Discharges" (December 2022). Accessed on Jan. 6, 2026.

[28] For the purposes of this report, we refer to any entity that performs tasks on behalf of an MAO as an "MAO contractor." These entities may include "first tier" entities, which enter into a written arrangement with an MAO to provide administrative services or health care services; "downstream" entities, which enter into an arrangement below the level of the arrangement between an MAO and a first tier entity; and "related" entities, which are related to the MAO by common ownership or control and perform some of the MAO's functions under contract or delegation. The MAO is responsible for assuring that its contractors and any downstream contractors have the information necessary to know how to comply with the requirements under the Medicare Advantage program. CMS, *Medicare Managed Care Manual*, Chapter 11: Medicare Advantage Application Procedures and Contract Requirements, Apr. 25, 2007. Accessed on Jan. 6, 2026.

[29] UnitedHealth Group, Inc., reported that "naviHealth is an indirect wholly owned subsidiary of UnitedHealth Group . . . naviHealth is a first tier downstream contractor and delegate of various UnitedHealthcare entities and also an affiliated entity through common indirect ownership by UnitedHealth Group."

[30] OIG, *Medicare Advantage Organizations Overturned Nearly All Appealed Prior Authorization Denials for Skilled Nursing Facility Admission, Raising Concerns About Initial Denials*, OEI-09-24-00331, June 11, 2026.

[31] CMS, "Part C Reporting Requirements." Accessed on Jan. 6, 2026.

[32] CMS, "Program Audits." Accessed on Jan. 6, 2026. As part of the program audits, CMS collected between 2 and 12 weeks of request-level prior authorization data for the MAOs under audit.

[33] Office of Management and Budget, OMB Control No. 0938-1489, "Service Level Data Collection for Initial Determinations and Appeals" (CMS-10905); Sept, 28, 2025. Accessed on Jan. 28, 2026,

[34] CMS, Service Level Data Collection for Initial Determinations and Appeals – Pilot Participation, Dec. 16, 2025. Available at: https://www.cms.gov/about-cms/information-systems/hpms/hpms-memos-archive-weekly/hpms-memos-wk-3-december-15-19.

[35] In the draft technical specifications, CMS plans to ask MAOs to provide health care procedure codes where applicable and available. For service requests that don't have an applicable service type code (including requests for admission to LTCHs, IRFs, and SNFs), MAOs can provide an open text description of the service being requested. For contractor details, CMS plans to ask MAOs to indicate whether or not a contractor was involved in the request review but not the name of the contractor.

[36] We asked MAOs to report data based on the date that the initial request decisions were issued. This means, for example, that a request that an MAO received at the end of June but had not yet issued a decision for by June 30, 2024, would not be included in our data. Similarly, decisions issued by MAOs at the beginning of June 2024 may include decisions for requests that were received in May.

[37] CMS, *MDS 3.0 Quality Measures User's Manual*, Version 17.0, Chapters 1 and 4, January 2025. Accessed on Dec. 1, 2025.

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