



Medicare Advantage Prior Authorization in Post-Acute Care: Issues and Interventions

PAC MA Coalition

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Executive Summary

This policy paper outlines key challenges and proposed solutions related to prior authorization (PA) practices in Medicare Advantage (MA) for post-acute care (PAC) services. It presents two targeted solutions:

1. Standardize all PA requests across MA plans; and
2. Reclassify all PAC-related PA requests and concurrent reviews as expedited and subject to a maximum 24-hour response time for coverage determination.

Together, these solutions aim to:

- **Ensure timely access to necessary PAC services** for beneficiaries, supporting patient recovery and maintenance while preventing avoidable decline; and
- **Reduce administrative burden** for both plans and providers by increasing the likelihood of initial PA approval and minimizing the need for repeated reviews;
- **Limit the number and frequency of subsequent requests** for continued coverage determinations (e.g., concurrent reviews) within an episode of care.

Importantly, these recommendations align with the Administration's commitment to strengthen Medicare, unleash prosperity through deregulation, and increase operational efficiency. By streamlining processes, reducing duplicative documentation, and improving care coordination, these reforms protect taxpayer resources while enhancing the delivery of timely, appropriate care for Medicare beneficiaries and reducing the administrative burden on providers and plans.

About PAC MA Coalition

Post-Acute Care (PAC) is made up of approximately 17,000 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 PAC Medicare Advantage (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, who combined represent 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 of participation.

Understanding the Issues

Medicare Advantage (MA) beneficiaries and providers continue to face ongoing challenges across the continuum of care, particularly with **prior authorization** (PA).

Prior Authorization

Prior authorization (PA) is the process through which a health plan grants approval for a service, treatment, or prescription before it is covered.

Although MA plans are required to follow a defined regulatory framework for PA ([42 CFR § 422.122](#) and [§ 422.138](#)), implementation remains fragmented and inconsistent, both across and within different plans. This variability imposes significant burdens on patients and providers, especially in post-acute care (PAC) settings.

PA requirements frequently delay or deny access to medically necessary PAC services, even when these services are supported by hospital discharge planning. An April 2022 report from the Office of the Inspector General ([OEI-09-18-00260](#)) found that 13% of denied PA requests, denied by MA plans, met Medicare coverage rules and likely would have been approved under Medicare fee-for-service (FFS).¹ The two most common reasons that MA plans denied these requests were:

1. Plan use of internal clinical criteria not supported by Medicare regulations; and/or
2. Plans' claiming insufficient documentation to support medical necessity.¹

In both cases, OIG physician reviewers determined that the requests met Medicare medical necessity standards and were adequately documented – across all service types, including PAC.¹

In [2024](#), the U.S. Senate Permanent Subcommittee on Investigations (PSI) examined PA requests for PAC services between 2019 and 2022. The subcommittee found that major national MA insurers denied PAC requests at rates up to 16 times higher than for other non-PAC services.² These denials and delays compromise patient outcomes, increase caregiver burden, threaten patient and family well-being, and undermine providers' ability to deliver timely, medically necessary care.

The Center for Medicare & Medicaid Services (CMS) recently conducted its first review of MA organizations' implementation of new Part C utilization management requirements, effective January 1, 2024.³ While CMS found general adherence, the [audit](#) reinforced earlier findings from the OIG and Senate PSI: MA plans continue to fall short in making timely and accurate coverage decisions and in ensuring that enrollees and providers have the information needed to appeal adverse determinations.³

Most MA plans require PA for PAC services, which often delays care initiation and prolongs hospital stays. A recent [NORC](#) study found that MA beneficiaries consistently experienced longer hospital stays prior to PAC discharge compared to those in Medicare FFS:

- Median inpatient hospital length of stay (LOS) prior to PAC discharge was seven days for MA versus five days for FFS.

- Median inpatient hospital LOS prior to LTACH discharge was nine days longer in MA than FFS.
- Discharges to IRF, SNF, and HHA were delayed by four, three, and two days, respectively.⁴

Between 2018 and 2022, median hospital LOS prior to PAC discharge remained steady at five days for Medicare FFS but increased by 16% for MA beneficiaries – from six to seven days.⁴ These delays contribute to unnecessary hospital utilization, higher healthcare costs, and strain on the acute care system.

Providers must wait for PA approval before delivering services or risk non-payment – even if the authorization is granted retroactively. This jeopardizes both patient health and provider financial stability. The uncertainty surrounding reimbursement forces providers to choose between delaying care or absorbing financial risk, both of which undermine care continuity and system efficiency.

Further complicating the process, each MA organization – and often each plan within the same organization – uses different communication channels (e.g., portals, facsimiles, and phone calls) and documentation requirements for PA and concurrent review. PAC providers must navigate multiple systems, increasing the risk of documentation errors and delays. Frequent system changes also require ongoing staff retraining. When PAC services are delayed or denied due to administrative complexity, the result can be avoidable hospitalizations and higher downstream costs to taxpayers.

Concurrent Review

Concurrent review is a form of utilization review that evaluates a beneficiary's eligibility and coverage for care while care is actively being delivered.

Even after an initial PA is approved, MA plans often conduct concurrent or subsequent reviews that result in early termination of services. These reviews typically prioritize cost containment over clinical appropriateness, leading to care disruptions, administrative burden, and delayed access to necessary care. Changes are frequently made without clinical justification or provider consultation, with the plan overriding clinical judgment and disrupting care continuity, while also creating financial challenges for PAC providers.

For example, a home health agency may receive initial PA approval for two visits, which only covers care initiation and assessment. A second authorization is then required to continue services, but it may take over a week to receive a decision from the plan. Providers and patients are then faced with difficult choices:

- Deliver care without authorization, risking non-payment; or
- Withhold services while awaiting plan approval, risking decline in the beneficiary's condition and slowing opportunities for improved outcomes.

Commitments to Prior Authorization Reforms

The *Interoperability and Prior Authorization* rule ([CMS-0057-F](#)), along with a June 2025 pledge from health insurers, has the potential to reshape and improve prior authorization (PA) processes in Medicare Advantage (MA). The rule sets requirements for faster decision making, electronic submission and communication of PA requests and corresponding plan responses via applicable programming interfaces (APIs) by 2027, and greater accountability through reporting on key PA metrics.⁵

In June 2025, nearly 50 health insurers – including the three largest national MA plans – pledged to “streamline, simplify, and reduce prior authorization...connecting patients more quickly to the care they need while minimizing administrative burdens on providers”.⁶ Their commitment was not limited to MA but echoed many of the requirements already outlined by [CMS-0057-F](#). Specifically, they promised to:

- Standardize electronic PAs by January 1, 2027;
- Provide real-time responses for at least 80% of electronic requests by January 1, 2027;
- Reduce the number of services subject to PA by January 1, 2026; and
- Improve communication of PA determinations, including “support for appeals and [clearer] guidance on next steps”.⁶

We are encouraged by plans’ public commitment to improving PA processes. However, despite recent pledges and regulatory momentum, measurable progress remains limited and PAC services are not mentioned in implementation communications.

Administration’s Commitment to Streamlining Regulations

On January 31, 2025, President Trump issued [Executive Order 14192](#), *Unleashing Prosperity Through Deregulation*, which aims to streamline regulations to reduce beneficiary, provider, and payer burden and costs of compliance.⁷ In response, the Centers for Medicare & Medicaid Services (CMS) issued a [Request for Information \(RFI\)](#) on April 11, seeking stakeholder and public input on potential changes to Medicare regulations, including Medicare Advantage, to achieve the goals of the executive order.⁸

The recommendations outlined in this document seek to address the unnecessary costs and burden associated with complying with myriad MA plan prior authorization processes by creating an efficient and standardized request form and accelerating decision timelines to ensure timely access to care for beneficiaries, while simultaneously reducing provider costs and burden associated with submitting PA and concurrent review requests. We believe these solutions align with the Administration’s broader goals to streamline regulations, the June 2025 pledge made by health insurers, and the expectations outlined in the Interoperability and Prior Authorization rule.

Policy Solutions

Solution #1: Standardization of prior authorization requests across all plans.

Post-acute care (PAC) providers face inconsistent prior authorization (PA) processes across Medicare Advantage (MA) plans. Insurers use different forms, data fields, and definitions of medical necessity and reasonableness, creating confusion, administrative burden, and delays in patient care. This variability also increases the risk of technical denials and documentation errors, delaying access to medically necessary PAC services.

Documentation requirements often vary widely, forcing providers to repeatedly submit the same information in multiple formats. Denial notices frequently lack sufficient detail, making it difficult for providers to respond effectively. These inconsistencies undermine operational efficiency and jeopardize timely, appropriate care delivery.

To address these challenges, the Center for Medicare & Medicaid Services (CMS) should require all MA plans adopt a standardized submission format, such as a uniform cover sheet, for services subject to PA, including PAC services. This standard format should be used both through the required PA Applicable Programming Interfaces (APIs) and any other submission channels.

A uniform cover sheet should be used across all plans and include the following standardized data elements/fields:

- Referral date
- Patient demographics
- Checkbox to indicate standard or expedited review
- Referring physician and facility information
- A checklist of services or settings to be authorized.
 - If selected, the list expands to include setting-specific criteria, which are to be regulated by CMS.
 - Includes a field to explain why care in the PAC setting is necessary and reasonable.
- Categories of admitting diagnoses with CPT code(s) or description(s)
- Freeform text entry field for provider notes Patient's physician or other provider information
- Discharge summary, if applicable and appropriate.
- Reference to additional documentation attached.

This standardized format would reduce administrative complexity, improve consistency across MA plans, and support timely decision-making. It would also advance CMS' and MA plans' shared goals of reforming PA processes for Medicare beneficiaries and reducing provider burden. An example of a standardized format for PAC services accompanies this solutions document.

Additionally, CMS should require MA plans to publicly report:

- Denial and appeal metrics for PA and coverage determinations at the service level; and
- Turnaround times and request times, segmented by provider/setting type.

These transparency measures would promote accountability and early identification of issues requiring attention and allow regulators and stakeholders to monitor plan performance.

To further reduce burden, both providers and MA plans should bear responsibility for retaining and referencing previously submitted beneficiary data. CMS should require MA plans to accept abbreviated PA requests during concurrent reviews (CRs), which mirror the original PA format but include only new information since the last request.

For concurrent reviews, PAC providers should only be required to submit:

- Current progress toward recovery or maintenance goals (e.g., recent clinical notes);
- Changes in condition or new assessments, if applicable;
- Medication adjustments since the initial PA or most recent CR request (e.g., new prescriptions, completed regimens, dosage changes); and
- Clinical notes from admission through the date of the CR request.

Further, CMS should establish that if an MA plan fails to provide a decision on a CR request within 24 hours, the request should be automatically approved, as the beneficiary is actively receiving care. This policy would incentivize plans to align utilization management practices with clinical standards, reduce inappropriate termination of services, and preserve continuity of care.

Currently, CR determinations linger for days, leaving both beneficiaries and providers uncertain about whether the services will be covered at all. Some MA plans have also informed providers that services rendered prior to receipt of an authorization will not be reimbursed—meaning that if providers continue services while awaiting a decision, they risk non-payment.

Solution #2: Prior Authorizations for PAC reclassified as expedited and subject to a 24-hour turnaround period.

Medicare Advantage (MA) plans frequently approve post-acute care (PAC) services for only a few days or visits, requiring frequent reauthorizations through concurrent review (CR) or subsequent prior authorization (PA) requests. This process places a significant strain on both clinical and administrative staff, diverting resources from direct patient care and contributing to PAC workforce burnout in an already strained sector.

Under current regulations, expedited PA requests must be processed within 72 hours, while standard (non-expedited) requests may take up to 14 calendar days—though this will be reduced to seven days beginning in 2026 ([42 CFR § 422.122](#) and [422.568](#)).

Expedited determinations are warranted when “the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function” ([42 CFR § 422.570](#)).

For patients transitioning from hospitals to PAC settings, standard timelines are too slow. Delays in PA approval disrupt safe care transitions, prolong costly inpatient hospital stays, and jeopardize continuity of care. Gaps in weekend and holiday processing, along with last-minute documentation requests, further exacerbate these delays.

We recommend CMS reclassify all PAs and concurrent reviews for PAC services as expedited and require these decisions be made within a 24-hour timeframe. Most patients referred to PAC are transitioning directly from acute care settings and are clinically vulnerable – conditions that clearly call for urgent review.

To strengthen accountability and ensure timely decisions, CMS should also require MA plans to confirm receipt of the PA request within 24 hours. If the plan fails to meet the required decision timeframe, the request should be automatically approved, as outlined in CMS contracts with MA organizations.

This policy would help acute care hospitals discharge patients more efficiently, freeing up beds for others in need and preventing patients from experiencing decompensation due to unnecessary extended hospital stays. In 2024, the American Hospital Association (AHA) reported that MA observation stays prior to PAC discharge were 12.6% longer than those in Medicare FFS.⁹ The Massachusetts Health and Hospital Association found that in 2023, approximately one in seven medical-surgical beds were occupied by patients in observation stay awaiting discharge to another care setting (Figure 1).¹⁰

These prolonged observation stays drive up hospital costs without a corresponding increase in reimbursement. Compared to inpatient admissions, observation stays are reimbursed at lower rates – or in some cases, not at all – leaving hospitals to absorb the cost.⁹ In 2024, MA plans reimbursed 49% of the actual cost for patients held in observation status, averaging over \$3000 per day.^{9,11}

For concurrent reviews, MA plans should be subject to a 24-hour maximum decision period. Additionally, review frequency should be capped at no more than once per week, unless the patient or provider discontinues services. This is critical as patients are already receiving care in PAC settings, and delays in reauthorization can interrupt delivery of medically necessary services.

Real-time or near-real-time decision-making is essential for patients being discharged to PAC. Delays in authorization contribute to care discontinuity, longer hospital stays, and risk poorer health outcomes – with associated costs ultimately borne by beneficiaries and taxpayers.

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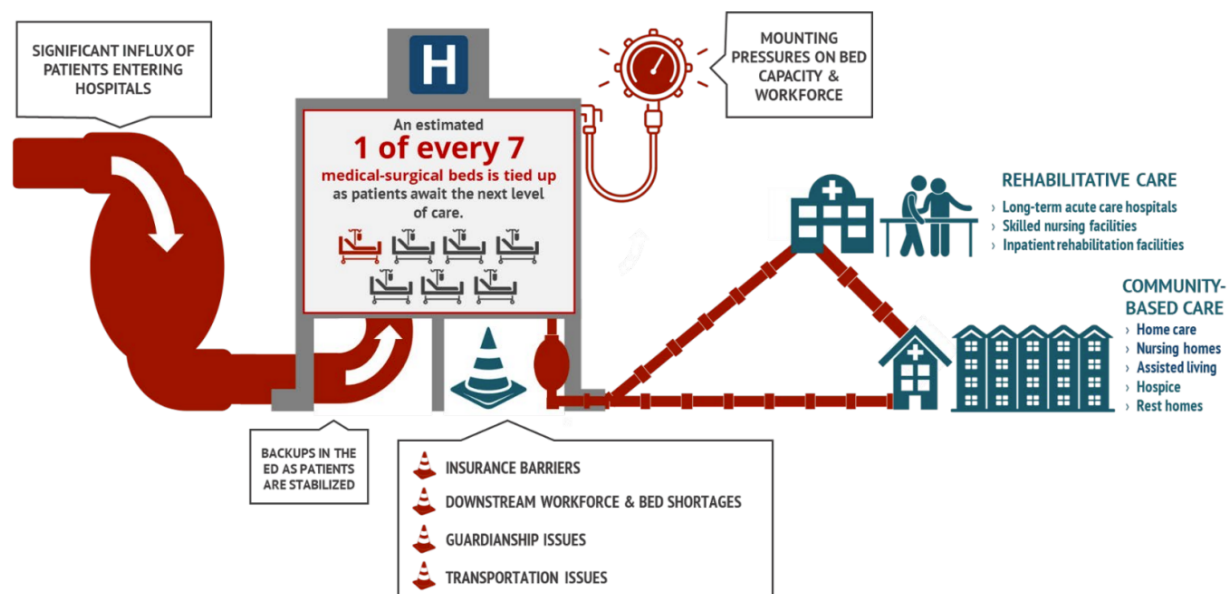
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A CLOGGED SYSTEM: How Hospital Backups Happen



The 15% of "tied up" beds was calculated by dividing the average number of patients in medical-surgical beds who were awaiting post-acute care or psychiatric discharge over the past 12 months by the average number of staffed medical-surgical beds in the 55 responding hospitals. Data was sourced from the Massachusetts Department of Public Health and MHA's monthly Throughput Survey and weekly Behavioral Health Boarding Survey. Non-participating hospitals were excluded from calculations.

Figure 1: [Massachusetts Health & Hospital Association, June 2023.](#)