May 13, 2026

SUBMITTED ELECTRONICALLY

The Honorable John Joyce
U.S. House of Representatives
c/o Matt Tucker
2102 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Murphy
U.S. House of Representatives
c/o McLean Piner
407 Cannon House Office Building
Washington, DC 20515

The Honorable Kim Schrier
U.S. House of Representatives
c/o Amy Zhou
1110 Longworth House Office Building
Washington, DC 20515

The Honorable Mariannette Miller-Meeks
U.S. House of Representatives
c/o Matt Brady
504 Cannon House Office Building
Washington, DC 20515

The Honorable Jimmy Panetta
U.S. House of Representatives
c/o Seamus McKeon
200 Cannon House Office Building
Washington, DC 20515

The Honorable Beth Van Duyne
U.S. House of Representatives
c/o Brayden Woods
1725 Longworth House Office Building
Washington, DC 20515

The Honorable Ami Bera
U.S. House of Representatives
c/o Asha Samuel
172 Cannon House Office Building
Washington, DC 20515

RE: Coalition to Preserve Rehabilitation Support for H.R. 8375, the Medicare Advantage Improvement Act

Dear Representatives Joyce, Murphy, Schrier, Miller-Meeks, Panetta, Van Duyne, and Bera:

On behalf of the undersigned members of the Coalition to Preserve Rehabilitation ("CPR"), we write to commend you for your bipartisan leadership and to express our strong support for H.R. 8375, the *Medicare Advantage Improvement Act ("MAIA")*. Medicare Advantage ("MA") increasingly serves Medicare beneficiaries with complex, disabling conditions who depend on timely access in medical rehabilitation services of all kinds, including inpatient rehabilitation

facility ("IRF") care, to achieve optimal recovery and maintain independence. However, persistent utilization management barriers—including prior authorization delays, inappropriate denials, and disruptions in care—continue to impede access to medically necessary rehabilitation services and undermine patient outcomes. CPR commends you and your leadership in introducing this critical legislation, which would address many of these well-documented MA shortcomings and, in turn, lead to better health outcomes for Medicare beneficiaries with disabilities and chronic conditions.

CPR is a coalition of more than 50 national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain the maximum level of health and independent function. CPR is comprised of organizations that represent patients—as well as the providers who serve them—who are frequently inappropriately denied access to rehabilitative care in a variety of settings.

MAIA includes critical reforms that will directly improve access to rehabilitation and post-acute care services, including IRF care. These provisions include the following:

Timeliness of Prior Authorization Decisions: MAIA strengthens prior authorization requirements and ensures timely decision-making, enforcing timelines for prior authorization requests, including 72 hours for standard requests and 24 hours for expedited determinations, which are particularly meaningful for patients transitioning from acute care hospitals to IRFs. For example, evidence-based practice guidelines state that stroke survivors require rapid initiation of intensive, interdisciplinary rehabilitation within a narrow window to maximize recovery, and delays in authorization can result in permanent loss of function. Similarly, patients with traumatic brain injuries often have rapidly evolving clinical needs, and delays in IRF admission can lead to cognitive decline, behavioral complications, or prolonged institutionalization. Post-surgical patients, including those recovering from major joint replacement of complex fractures, also rely on early access to intensive rehabilitation to prevent deconditioning, reduce fall risk, and avoid preventable hospital readmissions.

Routinely Approved Low-Risk Services: MAIA's requirement for real-time authorization decisions for routinely approved, low-risk services further supports efficient care transitions and reduces unnecessary administrative delays that too often interfere with timely IRF admission to post-acute care settings. Delays in acute care discharge also limit the acute care hospital's ability to clear beds and admit new patients in need of critical acute care.

"Anti-Clawback" Provisions: MAIA appropriately recognizes that rehabilitation care is inherently dynamic and must be responsive to patient progress. By prohibiting MA plans from denying or downgrading claims after prior authorization was granted, except in cases of fraud or clear error, the legislation helps ensure continuity of care across the rehabilitation continuum, including with IRFs. Medically complex patients frequently experience complications that necessitate continued rehabilitation, and without these protections, they are at risk of premature discharge, avoidable setbacks, and transition to less appropriate care settings.

Medical Necessity Criteria: Equally important, the legislation ensures that MA plans apply medical necessity criteria that are no more restrictive than those used under traditional fee-for-service Medicare, including for IRF coverage. This alignment is critical to ensure that patients who meet established clinical criteria for IRF or other post-acute care services are not improperly denied access or diverted to lower levels of care that cannot provide the same intensity of services. Inpatient rehabilitation facilities deliver coordinated, interdisciplinary care that is specifically designed to address complex functional impairments, and when access is restricted, patients often experience diminished recovery, increased caregiver burden, and higher long-term costs to the Medicare program.

Transparency and Oversight: The bill further strengthens transparency, oversight, and accountability within the MA program by requiring detailed, publicly available reporting of prior authorization data at the service-line level and by establishing a compliance scoring framework tied to financial accountability and Star Ratings. These provisions will improve visibility into plan behavior and help ensure that beneficiaries, providers, and policymakers can identify patterns of inappropriate denials that may disproportionately affect access to post-acute and rehabilitation services. In addition, the legislation includes important protections to ensure prompt payment for authorized services and to prevent retroactive denials or payment reductions after care has been delivered, absent fraud or similar fault. CPR believes that these safeguards are essential for many providers, including IRFs, which must make real-time clinical and operational decisions based on authorization approvals and cannot function effectively under conditions of payment uncertainty.

Network Adequacy: Finally, MAIA would address longstanding gaps in network adequacy by listing IRFs under the MA network adequacy standards, a provider setting to which beneficiaries are entitled if they qualify clinically. From the CPR's perspective, this provision is particularly important for beneficiaries who may not know the IRF setting is available to them, and individuals in rural and underserved areas, where limited network participation can create significant barriers to accessing appropriate levels of post-acute care. Ensuring that IRFs are adequately represented in MA networks will help guarantee that patients receive care in the most clinically appropriate setting without unnecessary delay or burden.

For individuals recovering from stroke, spinal cord injury, traumatic brain injury, major surgery, and other disabling conditions, access to timely, intensive medical rehabilitation is essential to restoring function, preventing complications, and enabling independent living. The *Medicare Advantage Improvement Act* represents a comprehensive and necessary step toward ensuring that the MA program supports these goals by improving prior authorization processes, aligning coverage standards, strengthening oversight, and safeguarding access to IRF care. For these reasons, CPR is proud to support this bill and we look forward to working with your colleagues in the Senate and House of Representatives to garner the support needed to advance and enact it into law in the 119th Congress.

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Should you have any further questions regarding this information, please contact Peter Thomas or Michael Barnett, coordinators for CPR, by e-mailing Peter.Thomas@PowersLaw.com or Michael.Barnett@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
ADVION
ALS Association
American Academy of Physical Medicine & Rehabilitation (AAPM&R)
American Association on Health and Disability
American Congress of Rehabilitation Medicine (ACRM)
American Dance Therapy Association
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Physical Therapy Association
American Spinal Injury Association (ASIA)
Association of Academic Physiatrists
Association of Rehabilitation Nurses
American Therapeutic Recreation Association
Brain Injury Association of America*
Center for Medicare Advocacy*
Clinician Task Force
Disability Rights Education and Defense Fund (DREDF)
Falling Forward Foundation*
Lakeshore Foundation
Muscular Dystrophy Association
National Association for the Advancement of Orthotics and Prosthetics (NAAOP)
National Association of Rehabilitation Providers and Agencies
RESNA
Spina Bifida Association
United Spinal Association*

**** CPR Steering Committee Member***