UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

SELECT MEDICAL CORPORATION, Plaintiff, v. AETNA NETWORK SERVICES LLC, Defendant.	Case No.

DEFENDANT'S NOTICE OF REMOVAL

PLEASE TAKE NOTICE that Defendant Aetna Network Services LLC ("Aetna") hereby submits this Notice of Removal to the United States District Court for the Middle District of Pennsylvania of the action filed by Plaintiff Select Medical Corporation ("Plaintiff") in the Court of Common Pleas of Dauphin County, Pennsylvania (Case No. 2026-CV-07514). The grounds for removal are as follows:

THE STATE COURT ACTION, PARTIES, AND PLEADING[1]

1. Plaintiff commenced the state court action against Defendant by filing a complaint in the Court of Common Pleas of Dauphin County, Pennsylvania on or about October 5, 2026. A copy of the Complaint is attached hereto as **Exhibit 1**.

2. Service was effectuated upon Aetna Network Services LLC on or about October 9, 2026 via its registered agent-in-fact, CT Corporation. *See* **Exhibit 2**.

[1] The following is taken from the face of the Complaint and any documents integral to the Complaint. Unless otherwise noted, the allegations of the Complaint are taken as true. Defendant reserves the right to deny and dispute any and all allegations as a factual or legal matter at the appropriate juncture and removes without waiver of any rights or defenses under the parties' agreement.

3. In the Complaint, Plaintiff alleges a breach of contract claim against Aetna under the Hospital Agreement effective July 1, 2026. *See* **Ex. 1**.

4. Aetna has not filed a responsive pleading in the state court action.[2]

PARTIES

5. Plaintiff Select Medical Corporation is a Pennsylvania corporation with a principal place in Pennsylvania. (Compl., Ex. 1 ¶ 14).

6. Defendant Aetna Network Services LLC is a Connecticut limited liability company that has one member and is 100% owned by Aetna Health Holdings, LLC, a Delaware entity. Aetna Health Holdings, LLC has one member and is 100% owned by Aetna Inc., a Pennsylvania company.

PROCEDURAL REQUIREMENTS

7. This original notice was timely pursuant to 28 U.S.C. § 1446(b) because it is filed within thirty-days of the earliest service of the Complaint on October 9, 2026. 28 U.S.C. § 1446(b)(1).

8. This action is properly removed to the United States District Court for the Middle District of Pennsylvania, which is "the district and division embracing the place where [the] action is pending." 28 U.S.C. § 1441(a).

GROUNDS FOR REMOVAL

9. Removal is appropriate under the federal officer removal statute, 28 U.S.C. § 1442(a)(1), because Plaintiff has sued Defendant for actions it took "under color of" federal law while acting under the direction of the Centers for Medicare & Medicaid Services ("CMS"). The federal officer removal statute permits removal of any action against:

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[2] A true and correct copy of the state court docket is attached as **Exhibit 3**.

> The United States or any agency thereof or any officer (or any person acting under that officer) of the United States or of any agency thereof, in an official or individual capacity, for or relating to any act under color of such office or on account of any right, title or authority claimed under any Act of Congress for the apprehension or punishment of criminals or the collection of revenue.

28 U.S.C. § 1442(a)(1).

10. The right of removal is "'absolute' . . . whenever a suit against a United States officer is filed in a state court for any act 'under color of federal office,'" regardless of whether the suit could originally have been brought in federal court. *Melo v. Hafer*, 912 F.3d 628, 641 (3d Cir. 1990) (quoting *Willingham v. Morgan*, 395 U.S. 402, 406–07 (1969)).

11. Where, as here, a defendant is not itself a federal officer or agency, federal officer removal may be had if the party attempting to remove demonstrates: it is a (1) person (2) acting under the United States, its agencies, or its officers (3) that has been sued for or relating to any act under color of such office, and (4) has a colorable federal defense to the plaintiff's claim. *Regional Med. Transp., Inc. v. Highmark, Inc.*, 541 F. Supp. 2d 718, 723 (E.D. Pa. 2008) (quoting *Feidt v. Owens Corning Fiberglas Corp.*, 153 F.3d 124, 127 (3d Cir. 1998)) (further citations omitted).

12. Each element is met here.

a. Defendant is a limited liability company, which constitutes a "person" for purposes of federal officer removal. 1 U.S.C. § 1 (defining "person" to include companies).

b. Defendant was assisting the federal government in reimbursing Plaintiff for its treatment of qualifying Medicaid or Medicare patients. *Regional Med. Transport*, 541 F. Supp. 2d at 724 ("Numerous federal courts have determined that [Medicare Advantage] carriers contracting with the United States Department of Health and Human Services operate under the direction of a federal officer.").

c. Plaintiff's claims target actions such as coverage and/or benefits determinations that were taken as a federal Medicare Advantage Organization. S*ee* Compl. ¶ 8 (alleging Aetna failed to determine coverage "without applying criteria more restrictive than the applicable Traditional Medicare requirements"); *Regional Med. Transport*, 541 F. Supp. 2d at 724 (finding defendants acted under comprehensive federal regulations in administering Medicare claims and that the alleged misconduct was directly related to those federally delegated duties, establishing the requisite "causal nexus between the claims and the conduct performed under color of a federal office." (quoting *Feidt*, 153 F.2d at 127)).

d. Finally, Defendant has colorable federal defenses, including Medicare preemption under the Medicare Act and its coverage decisions were a proper application of Medicare rules, regulations, and guidelines. *See, e.g.*, 42 U.S.C. § 1395w-26(b)(3) ("The standards established under this part shall supersede any State law or regulation with respect to [Medicare Advantage] plans which are offered by [Medicare Advantage] organizations ..."); *Regional Med. Transport*, F. Supp. 2d at 724–25 (holding that allegations arising from a carrier's administration of Medicare claims were removable where the carrier asserted colorable Medicare Act and official-immunity defenses).

NOTICES

13. In accordance with 28 U.S.C. § 1446(d), promptly after filing this Notice of Removal, Defendant will give written notice thereof to Plaintiff, and Defendant will file a copy of this Notice of Removal with the Court of Common Pleas of Dauphin County, Pennsylvania. A true and correct copy of the Notice of Filing of Notice of Removal is attached hereto as **Exhibit 4**.

RESERVATION OF RIGHTS

14. Defendant reserves all defenses and positions available to it at law, in equity or otherwise, and this Notice of Removal—which Defendant reserves the right to amend—shall not serve as a waiver of any such defense or position.

15. If any question arises regarding the propriety of the removal of this case, Defendant requests the opportunity to present further briefing in support of its position that the case is removable, including jurisdictional discovery to ferret out any factual disputes that Plaintiff may seek to raise.

CONCLUSION

16. For the foregoing reasons, Defendant respectfully demands that this action, previously pending in the Court of Common Pleas of Dauphin County, Pennsylvania, be removed to this Court.

Dated: November 6, 2026

Respectfully submitted,

s/Benjamin H. McCoy

Benjamin H. McCoy, Esq. (Pa. No. 314112)
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Attorneys for Aetna Network Services LLC

CERTIFICATE OF SERVICE

The undersigned hereby certifies that the original of the within Notice of Removal and supporting documentation has been electronically filed with the Clerk, United States District Court for the Middle District of Pennsylvania, within the time and manner prescribed by the rules of Court and that a copy of the within pleading has been served this date, via ECF and e-mail, upon all counsel of record on the state court docket.

Dated: November 6, 2026

s/Benjamin McCoy
Benjamin H. McCoy, Esq.

EXHIBIT 1

Dauphin County Prothonotary E-Filed - 05 Oct 2026 09:52:36 AM
Case Number: 2026-CV-07514

David R. Fine
Pennsylvania Supreme Ct. No. 66742
Anthony P. La Rocco
Pro Hac Vice Admission Forthcoming
George P. Barbatsuly
Pro Hac Vice Admission Forthcoming
Patrick J. Riley
Pennsylvania Supreme Ct. No. 333403

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ATTORNEYS FOR PLAINTIFF
SELECT MEDICAL CORPORATION

SELECT MEDICAL CORPORATION, 4714 Gettysburg Road Mechanicsburg, Pennsylvania 17055 *Plaintiff* v. AETNA NETWORK SERVICES LLC, 151 Farmington Avenue, Hartford, CT 06156 *Defendant*	IN THE COURT OF COMMON PLEAS DAUPHIN COUNTY, PENNSYLVANIA CIVIL ACTION – EQUITY No.

NOTICE TO DEFEND

You have been sued in court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this complaint and Notice are served, by entering a written appearance personally or by attorney and filing in writing with the court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so the case may proceed without you and a judgment may be entered against you by the court without further notice

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for any money claimed in the Complaint or for any other claim or relief requested by the plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER OR CAN NOT AFFORD ONE, GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL HELP.

DAUPHIN COUNTY LAWYER REFERRAL SERVICE
213 North Front Street
Harrisburg, PA 17101
(717) 232-7536

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ATTORNEYS FOR PLAINTIFF
SELECT MEDICAL CORPORATION

SELECT MEDICAL CORPORATION, 4714 Gettysburg Road Mechanicsburg, Pennsylvania 17055 *Plaintiff* v. AETNA NETWORK SERVICES LLC, 151 Farmington Avenue, Hartford, CT 06156 *Defendant*	IN THE COURT OF COMMON PLEAS DAUPHIN COUNTY, PENNSYLVANIA CIVIL ACTION – EQUITY No.

COMPLAINT

Plaintiff, Select Medical Corporation ("Select" or "Plaintiff"), by and through its undersigned counsel, brings this complaint for injunctive and equitable relief against Defendant, Aetna Network Services LLC ("Aetna" or "Defendant").

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1. Select is a post-acute care and rehabilitation hospital system that operates long term acute care hospitals ("LTCHs") throughout the United States, including nine locations in Central and Western Pennsylvania.[1]

2. Aetna is a health insurer that provides health care benefits, arranges for the delivery of health care services, and administers the provision of health care services for patients enrolled in one of Aetna's health insurance benefit plans.

3. Aetna contracts with Select to cover the medically necessary treatment Select provides to patients who subscribe to health insurance plans insured or administered by Aetna ("Members"), including members of Medicare Advantage plans that Aetna administers ("Medicare Members").

4. Most of Select's patients seek treatment at its LTCHs based on referrals from physicians in hospitals and other clinical settings who, in their medical judgment, determine that discharge to a long-term acute care hospital such as Select is the most appropriate level of care for the patient.

[1] The Pennsylvania LTCHs at issue in this Complaint are: Select Specialty Hospital – Johnstown, Inc. (320 Main St., Johnstown, PA 15901); Select Specialty Hospital – Laurel Highlands, Inc. (1 Mellon Way, Latrobe, PA 15650); Select Specialty Hospital – Erie, Inc. (252 West 11th Street, Erie, PA 16501); Select Specialty Hospital – Central PA, L.P. (Camp Hill Campus) (503 North 21st Street, Camp Hill, PA 17011); Select Specialty Hospital – Central PA, L.P. (York Campus) (1701 Innovation Drive, York, PA 17408); Select Specialty Hospital – McKeesport, Inc. (1500 5th Ave., McKeesport, PA 15132); Select Specialty Hospital – Pittsburgh/UPMC, Inc. (200 Lothrop Street, Pittsburgh, PA 15213); Select Specialty Hospital – Central PA, L.P. (Harrisburg Campus) (111 South Front Street, Harrisburg, PA 17101); and Select Specialty Hospital – Pittsburgh/UPMC, Inc. d/b/a Select Specialty Hospital – Alle Kiski (1301 Carlisle Street, Natrona Heights, PA 15065).

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5. Many of the plans covering Aetna's Members referred to Select require that Aetna preauthorize the patient's stay in an LTCH setting before Aetna will agree to cover the LTCH stay.

6. However, in violation of its contractual obligations to Select, Aetna has adopted an unpublished, but very real, policy of systematically denying Select's preauthorization requests for the admission of Aetna's Medicare Members to Select's LTCHs, including those located throughout the Commonwealth of Pennsylvania (the "anti-LTCH policy").

7. Although Aetna has not publicly disclosed its anti-LTCH policy, Aetna scrupulously follows it. Aetna routinely denies Select's preauthorization requests without citation to the appropriate clinical criteria governing LTCH admissions. On at least one occasion, Aetna's Vice President and Chief Medical Officer of National Medical Management candidly admitted to Select's Executive Vice President and Chief Medical Officer ("CMO") that Aetna believes "LTCHs have no value" and that Aetna will not approve coverage. On another occasion, a senior Medical Director for Aetna candidly admitted to Select's CMO that "I am told to say no" in response to Select's requests for preauthorization for patient admissions to LTCHs.

8. Aetna's anti-LTCH policy is in direct violation of its contract with Select, by which Aetna agreed to authorize medically necessary services available under the traditional Medicare fee-for-service program ("Traditional Medicare")[2] to Aetna's

[2] The Traditional Medicare requirements are sometimes also referred to as "Original Medicare."

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Medicare Members without applying criteria more restrictive than the applicable Traditional Medicare requirements.

9. Through its anti-LTCH policy, Aetna is putting the lives and safety of its Members at risk, as the United States Department of Health and Human Services Office of Inspector General ("OIG") has recently recognized in a June 2026 report. Of particular concern, the LTCH population heavily involves pulmonary and chronic critical care, yet the decision makers involved in Aetna's decisions to refuse to authorize LTCH care typically do not practice in pulmonary and chronic critical care and have no other relevant experience with the direct clinical care or expected clinical outcomes of the LTCH population.

10. Aetna's anti-LTCH policy also threatens irreparable damage to Select's reputation and goodwill. As noted above, most of Select's patients originate from referrals from physicians in hospitals and other clinical settings. However, Aetna's practice of systematically refusing to preauthorize admission of Aetna's Members to Select's LTCHs has discouraged many referring physicians from referring Aetna's Members to Select, realizing that Aetna sees no value in Select's LTCHs and that such referrals will be futile.

11. In turn, Aetna's anti-LTCH policy has eroded and threatens to continue eroding Select's reputation and standing in the medical community, and the public at large. Indeed, as Aetna's anti-LTCH policy causes physician referrals to diminish, the medical community, and the public at large, will inevitably begin to conclude that Select's LTCHs are not a viable treatment option for patients, even though LTCHs

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have long been recognized as medically necessary for patients in need of hospital-level care for extended periods of time following discharge from a general acute-care hospital.

12. Accordingly, to prevent further irreparable harm to Select and the patients it serves, Select now brings this Complaint for injunctive and equitable relief to bar Aetna from continuing to pursue its anti-LTCH policy.

13. Although the parties' agreement contains an arbitration provision, that provision expressly excludes "injunctive relief or any other form of equitable relief" from its scope. Because Select seeks only injunctive and equitable relief, this action is properly brought before this Court. In support of this Complaint, Plaintiff avers as follows:

THE PARTIES

14. Select is a Pennsylvania corporation with a principal place of business at 4714 Gettysburg Road, Mechanicsburg, Pennsylvania 17055.

15. Aetna is a limited liability company with a principal place of business at 151 Farmington Avenue, Hartford, Connecticut 06156. Aetna's sole member is Aetna Health Holdings, LLC, whose sole member is Aetna Inc., a Pennsylvania corporation.

JURISDICTION AND VENUE

16. This Court has jurisdiction over this action pursuant to 42 Pa.C.S. § 5301(a)(2), and venue is proper in Dauphin County, Pennsylvania, pursuant to Pa. R.C.P. 2179(a)(2) and 2179(a)(4). Aetna regularly conducts business in Dauphin County, and the transactions and occurrences giving rise to Select's claims, including

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Select's submission of requests for preauthorization to admit Aetna's Medicare Members to its LTCHs and Aetna's denial of those requests, took place, in whole or in part, in Dauphin County.

17. While the agreement between Select and Aetna contains an arbitration provision governing "[a]ny controversy or claim arising out of or relating to this Agreement," it expressly excludes "injunctive relief or any other form of equitable relief" from its scope.[3] Exhibit A at § 7.2. Because Select's Complaint seeks only injunctive relief, this action falls squarely within the § 7.2 exclusion and is thus properly before this Court rather than in arbitration.

BACKGROUND

18. Select was co-founded by the late philanthropist and healthcare executive professional, Rocco A. Ortenzio, and his son, Robert A. Ortenzio, in 1996. Select began as a regional provider of outpatient physical rehabilitation and its health care services later expanded to include long-term acute care hospitals in 1998.

19. Select's LTCHs deliver essential post-hospital care to Aetna Medicare Members whose acuity requires continued hospital-level treatment following discharge from a short-term acute care hospital.

20. Select's LTCHs provide medically necessary long term acute care services to patients who require prolonged hospital-level care that cannot safely be delivered in less intensive settings, including services such as prolonged mechanical ventilation and weaning, complex wound care, multi-system organ support, and

[3] A true and correct copy of the current agreement between Aetna and Select is attached hereto as Exhibit "A."

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intensive rehabilitation therapies. Select's LTCHs also serve a critical role in admitting medically complex and positive patients during a pandemic such as COVID-19, particularly those requiring prolonged mechanical ventilation or tracheostomies.

21. Select's LTCHs deliver medically necessary hospital-level care to patients whose acuity exceeds what a skilled nursing facility is licensed, staffed, or equipped to provide, and whose conditions require ongoing physician-directed interventions.

22. When patients are denied timely transfer to LTCHs, they are forced to remain in short-term acute care hospitals longer than necessary, exposing them to increased risk of hospital-acquired infections, functional decline, and other adverse patient outcomes.

23. Select therefore fills a critical need in Pennsylvania communities by providing hospital-level long term acute care to patients whose medical acuity requires it, in facilities equipped and staffed to deliver that specialized level of care.

AETNA'S OBLIGATIONS UNDER ITS AGREEMENT WITH SELECT

24. Select and Aetna began their contractual relationship for Select's Pennsylvania facilities in or around 2009, when they entered into an agreement by which Select would provide long term acute care services to Aetna's members in exchange for reimbursement at contractually agreed rates. That relationship has continued through a series of successor agreements, the most recent of which is the Hospital Agreement effective July 1, 2026 (the "Agreement").

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25. Under the Agreement, "Covered Services" are "[t]hose health care and related services for which a Member is entitled to receive coverage or program benefits under a Plan." Exhibit A at "Definitions."

26. Additionally, under the Agreement, a "Member" means "[a] person covered by or enrolled in a Plan" including "the subscriber and any of the subscriber's eligible dependents." Exhibit A at "Definitions."

27. "Plan" is defined as "[a] health care benefits plan or program for which [Select] serves as a Participating Provider; the terms of each specific Plan are outlined in the applicable summary plan description, certificate of coverage, evidence of coverage, or other coverage or program document." Exhibit A at "Definitions."

28. "Applicable Law" is defined to include "[a]ll applicable Federal and state laws, regulations and governmental directives related to this Agreement." Exhibit A at "Definitions."

29. In the Agreement, Aetna agreed that "it is, and will remain throughout the term of this Agreement, in material compliance with Applicable Law related to its performance of its obligations under this Agreement." Exhibit A at § 2.1(c).

30. When Aetna administers Medicare Advantage plans for its Medicare Members, Aetna serves as a Medicare Advantage Organization ("MAO") under Part C of the federal Medicare Act.

31. As an MAO, Aetna is required by statute to provide its Medicare Members with the benefits available under Traditional Medicare, including LTCH benefits. 42 U.S.C. § 1395w-22(a)(1)(A),(B)(i).

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32. Aetna must therefore provide the LTCH benefits available under Medicare Part A, including by arranging for medically necessary LTCH services through the authorization of qualifying Medicare Members' admissions to LTCHs. *See* 42 U.S.C. § 1395w-22(a)(1)(A), (B)(i); 42 C.F.R. § 422.101(a).

33. In adjudicating preauthorization requests for LTCH admission, Aetna must also apply the Traditional Medicare coverage and benefit conditions governing inpatient admissions, including the criteria set forth in 42 C.F.R. § 412.3. 42 C.F.R. § 422.101(b)(2).

34. Where coverage criteria are not fully established in applicable Medicare statutes, regulations, national coverage determinations, or local coverage determinations, an MAO may create publicly accessible internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature. 42 C.F.R. § 422.101(b)(6).

35. Any internal coverage criteria applied by an MAO, however, may be "no more restrictive than Traditional Medicare's national and local coverage criteria." Exhibit B at 26.

36. As CMS further explained in its response to the OIG Report, MAOs must make medical-necessity determinations "based on the circumstances of each specific individual, including the patient's medical history, physician recommendations, and clinical notes." *Id.*

37. Accordingly, in adjudicating requests for preauthorization of LTCH admissions, Aetna may not apply internal coverage criteria that are more restrictive

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than the applicable Traditional Medicare criteria and must make medical-necessity determinations based on each Medicare Member's individual circumstances, including the Member's medical history, physician recommendations, and clinical notes.

38. The MAO regulations prohibit MAOs such as Aetna from establishing restrictions on the site of service setting for basic benefits if such restrictions do not exist in Traditional Medicare. In promulgating these MAO regulations, CMS specifically explained that "under our proposal at § 422.101(c)(1)(i), when care can be delivered in more than one way or in more than one type of setting, and a contracted provider has ordered or requested Medicare covered items or services for a Medicare Advantage enrollee, the MAO may only deny coverage of the services or setting on the basis of the ordered services failing to meet the [Traditional Medicare] criteria outlined in § 422.101(c)(1)(i)." 88 Fed. Reg. 22120, 22190 (Apr. 12, 2023). This limits MAO plans' ability—including Aetna—to restrict when and how covered benefits are furnished when Traditional Medicare will cover different provider types or settings.

39. For example, if a physician orders discharge to an LTCH, then a MAO payor cannot deny coverage for LTCH level care and redirect the patient to a skilled nursing facility, unless the patient does not meet the coverage criteria required for LTCH care. In other words, a Medicare Advantage Plan may not deny coverage based on its preference for a lower-cost or lower intensity care setting, if the patient meets the established Traditional Medicare coverage criteria for the setting ordered or requested by the treating physician.

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40. The "Medicare Advantage Product Addendum" to the Agreement further clarifies that "Applicable Law" includes "all applicable orders, directives, instructions, subregulatory guidance, and other requirements of any Official, including requirements for Medicare Advantage plans that pertain to participation as a First Tier or Downstream Entity in the Medicare Advantage Program." Exhibit A, Medicare Advantage Product Addendum at § 1.

41. As noted above, under the Agreement, Aetna is required to remain "in material compliance with Applicable Law related to its performance of its obligations under this Agreement." Exhibit A at § 2.1(c). This means that in adjudicating Select's requests for preauthorization of LTCH admission, Aetna is contractually required to apply the Traditional Medicare requirements incorporated into the Agreement and may not apply internal coverage criteria that are more restrictive than the applicable Traditional Medicare criteria.

42. At all relevant times, and in full accordance with its obligations under the Agreement, Select has remained ready and willing to provide medically necessary long term acute care services to Aetna's Members referred to its Pennsylvania LTCHs and has submitted the preauthorization requests at issue as required under the Agreement.

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AETNA BREACHES THE AGREEMENT

43. Despite Select's performance of its obligations under the Agreement, Aetna has engaged in a pattern of systematically denying preauthorization requests for the admission of Aetna's Medicare Members to Select's LTCH facilities, in violation of the Agreement.

44. Specifically, Aetna has adopted its unpublished, but very real, anti-LTCH policy, by which it has engaged in a nationwide practice of systematically denying Select's requests to preauthorize the admission of Aetna's Medicare Members to Select's LTCHs, including Select's Pennsylvania LTCH facilities, by applying criteria and practices that go beyond, and are more restrictive than, the applicable Traditional Medicare requirements.

45. Upon information and belief, Aetna's anti-LTCH policy is driven by the financial incentive inherent in the Medicare Advantage program's capitated payment model. Under Medicare Advantage's capitated payment model, MAOs are paid a risk-adjusted, capitated payment each month for each enrollee regardless of the number of services the enrollee receives.

46. As the OIG recognized, that model creates "the potential incentive for insurers to deny enrollees' access to services in an attempt to increase profits." Exhibit B at 3. Because Aetna receives a fixed monthly payment for each Medicare Member regardless of the services that Member receives, denying admission to an LTCH allows Aetna to avoid the cost of medically necessary LTCH care and retain a greater portion of that payment.

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47. Although Aetna has not publicly disclosed its anti-LTCH policy, as noted above, Aetna has acknowledged that it maintains such a policy, candidly telling Select's representatives that it sees "no value" in LTCHs.

48. Moreover, Aetna's anti-LTCH policy is borne out by Aetna's conduct. Specifically, in 2025, Aetna denied preauthorization requests for admission for 200 of the 207 patients referred to Select's Pennsylvania LTCHs. Similarly, in 2026 through June 30, 2026, Aetna denied Select's preauthorization requests for 108 of the 114 patients referred to Select's Pennsylvania LTCH facilities. This amounts to astonishingly low admission rates of 3.4% for 2025 and 5.3% for January 1, 2026, through June 30, 2026. Aetna's admission rate was the lowest among the principal payors evaluated in the Pennsylvania market during those periods.

49. Aetna's extraordinarily high denial rate in Pennsylvania is not an isolated occurrence. Although Aetna's denial rates in other states are lower than the rates in Pennsylvania, they nevertheless remain higher than those of its peer payors. For example, in Ohio, Aetna's LTCH admission rates were 11.3% in 2025 and 7.5% for the period January 1, 2026, through June 30, 2026.

50. Together, these state-specific data demonstrate that Aetna's anti-LTCH policy extends beyond Pennsylvania and is part of a nationwide pattern of systematically denying preauthorization requests for the admission of Medicare Members requiring medically necessary LTCH care.

51. Moreover, Aetna's denials are not isolated preauthorization determinations. Rather, they reflect a systematic practice of denying requests for the

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admission to Select's LTCH facilities of Aetna's Medicare Members who require medically necessary LTCH-level care.

52. Aetna maintains its anti-LTCH policy even though LTCH services are covered under Traditional Medicare and, therefore, Aetna is required to provide those benefits under the Agreement and Applicable Law. Aetna's financial interests do not permit it to impose more restrictive criteria or deny qualifying LTCH admissions merely to avoid the cost of providing medically necessary care. Yet, through its anti-LTCH policy, Aetna does exactly that.

OIG Findings Expose Aetna's Anti-LTCH Policy

53. Aetna's financially motivated, systematic anti-LTCH policy has recently come under scrutiny by federal authorities, and it has been documented as an industry-wide problem, with Aetna's parent company recognized as the worst offender.

54. In June 2026, the United States Department of Health and Human Services Office of Inspector General ("OIG") issued a data brief titled *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 (June 2026) (the "OIG Report"). A true and correct copy of the OIG Report is attached hereto as Exhibit "B."

55. The OIG Report found that the three largest MAOs by enrollment—including CVS Health Corporation, Aetna's ultimate parent company—denied prior authorization requests for LTCH admission at higher rates than most of their peers.

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Exhibit B at 2, 5. In June 2024, CVS Health Corporation denied approximately ***80 percent*** of LTCH admission requests it received—the highest LTCH denial rate of any MAO studied and nearly double the 42 percent denial rate for the other 16 MAOs analyzed. Exhibit B at 2, 5.

56. The OIG identified as a "central concern" that Medicare Advantage organizations' capitated payment model creates "the potential incentive for insurers to deny enrollees' access to services in an attempt to increase profits." Exhibit B at 3. The OIG further found that "[i]nappropriate 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." *Id.*

57. The OIG Report corroborates the profit-motive concern with data: for-profit MAO contracts, including all of CVS Health Corporation's Medicare Advantage contracts, denied LTCH admission requests at a rate of 67 percent—nearly double the 39 percent denial rate of nonprofit MAO contracts. Exhibit B at 7, 22. And CVS Health Corporation's own denial rate exceeded even the for-profit average, denying approximately four out of every five prior authorization requests. Exhibit B at 5.

58. The OIG also documented the patient-harm consequences of MAO denials of post-acute care. When Medicare Advantage members are denied timely transfer to appropriate post-acute care settings—including LTCHs—they are typically forced to remain in acute-care hospitals awaiting an MAO decision. *Id.* at 9. As the OIG has recognized, "[s]pending extra days in an acute hospital setting can . .

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. increase a patient's risk of hospital-acquired patient complications (e.g., health care-associated infections and falls)." *Id.* at 10.

59. In prior work cited in the OIG Report, OIG physician reviewers reviewed a sample of denied MAO prior authorization requests and found that 13 percent involved services that "met Medicare coverage rules"—meaning "these services likely would have been approved if the patients had been enrolled in original Medicare rather than in Medicare Advantage." *Id.* at 4.

60. The OIG Report goes on to explain that "[o]ne 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.***" *Id.* (emphasis added).

The Ongoing Harm Resulting from Aetna's Systemic Practices

Harm to Patients

61. Aetna's denial of medically necessary LTCH care places its Medicare Members at risk of serious harm. When Aetna refuses to authorize LTCH care, patients may be forced to remain in short-term acute care hospitals longer than medically necessary or may be discharged to settings, including skilled nursing facilities or their homes, that cannot provide the hospital-level care their conditions require.

62. Of particular concern, the Medical Directors and other decision makers involved in Aetna's decisions to refuse to authorize Select's LTCH do not practice in

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the areas of pulmonary and chronic critical care, even though the LTCH population is heavily represented by patients in need of these medical specialties.

63. Patients who remain in short-term acute care hospitals because Aetna has denied authorization for LTCH care are deprived of timely access to the specialized, extended hospital-level treatment prescribed by their treating clinicians. These delays may expose patients to an increased risk of hospital-acquired infections, falls, functional decline, and other adverse outcomes associated with unnecessarily prolonged hospitalization. As the OIG has recognized, spending additional days in an acute-care hospital while awaiting appropriate post-acute placement can increase a patient's risk of hospital-acquired complications. Exhibit B at 9–10.

64. Patients discharged to a level of care lower than an LTCH setting face different but equally serious risks. A skilled nursing facility or home setting may not provide the intensive physician oversight, respiratory therapy, ventilator management, complex wound care, skilled nursing, specialized equipment, or coordinated treatment available at an LTCH. When patients requiring LTCH-level care are discharged to such settings, they may experience interruptions in medically necessary treatment, clinical deterioration, emergency hospitalization, or readmission to a short-term acute care hospital.

65. Thus, Aetna's denial of LTCH care does not merely determine the setting in which a patient receives otherwise equivalent services. Rather, it may prevent or delay patients from receiving the level, intensity, and coordination of care

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determined to be medically necessary by their treating clinicians, exposing those patients to serious and potentially irreversible harm.

66. A recent report of the OIG in connection with CVS Health Corporation, Aetna's corporate parent, exposed the harm caused by Aetna's anti-LTCH policy. In particular, as the OIG report found, Aetna's denials of LTCH admission requests have forced Aetna's Medicare Members to remain in short-term acute care hospitals or to be directed to lower levels of care, such as skilled nursing facilities, when their treating clinicians determined that LTCH-level care was medically necessary. Those practices expose Aetna's Medicare Members to an increased risk of hospital-acquired infections, functional decline, and adverse patient outcomes.

67. The experiences of Aetna's Medicare Members confirm that these risks are neither hypothetical nor speculative. The following examples represent only a sampling of the patients affected by Aetna's anti-LTCH policy and demonstrate how Aetna's denials have prevented or delayed patients from receiving medically necessary LTCH care and have exposed those patients to precisely the harms identified by the OIG.

Patient D.S.

68. For example, one Aetna Medicare Member ("Patient D.S."), a ventilator-dependent patient with a tracheostomy who was recovering from an intracranial hemorrhage complicated by respiratory failure, required daily physician oversight and respiratory-therapy intervention for ventilator weaning that could be safely provided only at an LTCH level of care. Despite her clear clinical need, Aetna denied

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the request for her admission to Select's LTCH. As her treating critical-care physician documented contemporaneously, "LTACH request denied yesterday. Appealing today."

69. Aetna's denial forced Patient D.S. to remain in a short-term acute care hospital rather than transfer to the LTCH-level care her physicians had determined was medically necessary. While she remained in the acute-care setting awaiting LTCH placement, she suffered precisely the kinds of harm the OIG has warned may result from such delays. During that period, her treating physician documented that he was "concerned she may be starting to develop a pneumonia," noting "increasing fevers and secretions," a temperature rising to 38.8°C, and oxygen saturation falling as low as 81%. She continued to fail ventilator-weaning trials, at one point requiring manual bag ventilation due to desaturations and failing a spontaneous breathing trial.

70. Patient D.S. also suffered the functional decline and adverse outcomes that flow from prolonged confinement in a setting ill-suited to her needs. By the time of her subsequent screening, she had developed a large, unstageable sacral pressure ulcer measuring 11 by 11 centimeters with black eschar, necessitating a surgical consultation for debridement and an offloading mattress. Patient D.S.'s deterioration, including an evolving respiratory infection, repeated failed weaning, and a severe pressure wound, reflects precisely the increased risk of hospital-acquired infection, functional decline, and adverse patient outcome that the OIG identified as the

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foreseeable consequences of Aetna's improper denials of medically necessary LTCH admissions.

Patient M.N.

71. The experience of a second Aetna Medicare Member ("Patient M.N.") likewise exemplifies these practices. Patient M.N., a 69-year-old ventilator-dependent man with a tracheostomy placed on April 16, 2026, was admitted in acute hypoxic respiratory failure following recurrent MRSA pneumonia. He required frequent skilled airway suctioning for a high secretion burden, daily physician-led medical management, daily pulmonology oversight, and intensive respiratory therapy multiple times per day. His clinicians documented that he was "not clinically appropriate for discharge to a skilled nursing facility, nor does he meet criteria for inpatient rehabilitation, as he is unable to tolerate three hours of daily therapy secondary to respiratory instability and overall medical acuity." They concluded that Patient M.N. "meets Aetna Medicare criteria for LTACH admission" and that "admission to an LTACH is medically necessary and represents the safest and most appropriate level of care under Aetna Medicare guidelines."

72. Aetna nevertheless denied the request for Patient M.N.'s admission to Select's LTCH. On April 27, 2026, his treating hospitalist recorded his disposition as "Extended Care Facility, awaiting appeal for Select Specialty Hospital," while also documenting that Patient M.N. was "Medically Ready: Ready Now." The hospitalist made the same entries the following day. Patient M.N. was, in other words, medically

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ready for LTCH-level care and held in a short-term acute care hospital solely because Aetna had refused to authorize it.

73. Patient M.N. deteriorated while he remained in the short-term acute care hospital awaiting LTCH care. Although he had been weaning successfully before the records identified his disposition as "awaiting appeal for Select Specialty Hospital," that progress reversed while he remained in the acute-care setting. On April 28, 2026, he suffered severe oxygen desaturation requiring transfer back to the intensive care unit and replacement on the ventilator. He thereafter required vasopressor support, developed recurrent MRSA pneumonia and worsening multilobar pneumonia or pulmonary edema with increased bilateral pleural effusions, and suffered a stage 2 sacral pressure injury and continued functional dependence. Patient M.N.'s course reflects the increased risk of infection, functional decline, and adverse patient outcomes that the OIG identified as the foreseeable consequence of delays in medically necessary LTCH care.

Patient L.S.

74. The experience of a third Aetna Medicare Member ("Patient L.S.") provides another striking example of the disconnect between a patient's documented medical acuity and Aetna's determination that the patient's needs could be met at a lower level of care. Patient L.S. underwent coronary artery bypass surgery on April 28, 2026, after which he experienced a prolonged and medically complicated postoperative course. By May 27, 2026, Patient L.S. had suffered acute hypoxic and hypercarbic respiratory failure requiring reintubation and placement of a

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tracheostomy and remained dependent on ventilatory support while undergoing only partial T-piece and tracheostomy-mask trials. He also required hemodialysis for dialysis-dependent acute kidney injury superimposed on chronic kidney disease, therapeutic anticoagulation for active thromboses, enteral nutrition, and wound care. These simultaneous conditions required extensive multidisciplinary management of Patient L.S.'s respiratory, renal, cardiovascular, neurologic, hematologic, nutritional, and rehabilitative needs.

75. Aetna nevertheless denied authorization for Patient L.S.'s admission to a Select LTCH on May 27, 2026, stating that he was stable and that his needs could be met at a lower level of care. Yet Patient L.S.'s apparent stability was achieved through intensive hospital-level interventions, including structured ventilator weaning, nocturnal ventilatory support, tracheostomy management, hemodialysis with active volume and electrolyte management, high-risk anticoagulation, and daily physician-directed management of multiple active organ systems. Aetna's denial did not explain how any lower-acuity setting could safely provide this combination of concurrent and interdependent services.

76. Patient L.S.'s subsequent clinical course further demonstrates that his need for extended hospital-level care was real and ongoing. Following Aetna's denial, Patient L.S. suffered a pulseless electrical activity arrest, required recurrent transfers to the intensive care unit, underwent a thoracentesis and placement of a percutaneous endoscopic gastrostomy tube, continued to require dialysis, and remained dependent on tracheostomy-based respiratory support. In late June and

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early July, more than a month after Aetna's denial, Patient L.S. continued to require mechanical ventilation or high-flow respiratory support, dialysis, enteral nutrition, and extensive assistance with basic mobility despite ongoing multidisciplinary treatment. His prolonged hospitalization and continuing need for intensive treatment confirm that his medical complexity and need for hospital-level care were not temporary and underscore the disconnect between his documented clinical condition and Aetna's determination that he was appropriate for a lower level of care.

Patient S.H.

77. The experience of a fourth Aetna Medicare Member ("Patient S.H.") further demonstrates Aetna's practice of repeatedly denying authorization for LTCH admission despite a patient's persistent need for hospital-level care. Patient S.H. suffered severe bilateral posterior-circulation ischemic strokes that caused aphasia, hemiparesis, encephalopathy, inconsistent command following, and profound functional dependence. Her condition was further complicated by a pulmonary embolism, bilateral proximal deep-vein thromboses requiring placement of an inferior vena cava filter, a history of intracranial hemorrhage, and other serious medical conditions. On March 9, 2026, Patient S.H. underwent placement of a tracheostomy and percutaneous endoscopic gastrostomy tube and remained dependent on mechanical ventilation, enteral feeding, respiratory therapy, secretion management, and multidisciplinary medical care.

78. Aetna nevertheless denied authorization for Patient S.H.'s admission to an LTCH on March 13, 2026, stating that she was not expected to benefit from or

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improve with LTCH services, that her medical needs were stable, and that she was ready for discharge to a lower level of care. Aetna asserted that Patient S.H.'s needs could be met in an acute rehabilitation facility, skilled nursing facility, nursing facility, outpatient setting, or home-care setting. On March 22, 2026, Aetna again denied authorization for LTCH admission on substantially the same grounds. Aetna's denial rationales did not explain how any of the proposed lower-acuity settings could safely provide the mechanical ventilation, tracheostomy care, enteral feeding, respiratory treatment, secretion management, and coordinated medical oversight that Patient S.H. continued to require.

79. Aetna's repeated denials did not result in Patient S.H.'s discharge to one of the lower-acuity settings Aetna claimed was appropriate. Instead, Patient S.H. remained hospitalized and continued to require hospital-level care. By late May 2026, she remained dependent on continuous mechanical ventilation through a tracheostomy, required repeated respiratory treatments and tracheal suctioning, remained largely confined to bed and unable to reposition herself, inconsistently followed commands, and continued to undergo ventilator-weaning attempts. A respiratory assessment on May 29, 2026, continued to identify her as requiring continuous mechanical ventilation and recommended aerosol therapy and bronchopulmonary-hygiene treatment every four hours.

80. Despite Patient S.H.'s continued ventilator dependence and inability to transition safely from the short-term acute care hospital following Aetna's earlier denials, Aetna denied another request for LTCH admission on June 2, 2026. Aetna

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again concluded that an LTCH was not appropriate and asserted that Patient S.H.'s needs could be met in less intensive settings. Aetna repeatedly denied LTCH admission even after Patient S.H.'s continued hospitalization demonstrated that the proposed lower levels of care were not realistic alternatives. Those repeated denials reflect a fundamental disconnect between Aetna's generalized denial rationales and Patient S.H.'s documented clinical condition, treatment requirements, and actual discharge options.

Patient S.C.

81. The experience of a fifth Aetna Medicare Member ("Patient S.C.") provides another example of Aetna denying authorization for LTCH admission despite the patient's treating physicians' determination that LTCH-level care was appropriate. Patient S.C. suffered multiple embolic strokes and acute hypoxic respiratory failure requiring a tracheostomy and ventilatory support. She also experienced dysphagia requiring enteral nutrition, cognitive and communication impairments, atrial fibrillation requiring anticoagulation, fractures of the first and second metatarsals that left her unable to bear weight on her left leg, pressure injury, and profound functional dependence. Her treating neurologist expressly recommended "LTAC then IPR when vent weaned" and separately stated: "Plan is repeat MRI and get to LTAC. We have to get this patient moving. Select Specialty would be my bias."

82. Select requested authorization for Patient S.C.'s admission to its LTCH, but Aetna denied the request on December 8, 2025, asserting that she did not satisfy

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its criterion requiring an expected LTCH stay of at least 25 days and that her needs could be met in a lower-acuity setting. Patient S.C. nevertheless remained in the short-term acute care hospital until December 23. During that period, she remained tracheostomy-dependent and nonverbal, could not tolerate a speaking-valve trial because of increased work of breathing and decreased oxygen saturation, continued to require enteral nutrition, and underwent PEG placement after interruption and bridging of her anticoagulation.

83. On the day of her eventual discharge to a lower-acuity facility, Patient S.C. required cardiology evaluation for recurrent atrial fibrillation with rapid ventricular response, with heart rates reaching the 150s to 160s, and experienced severe hyperglycemia, with serum glucose of 443 and point-of-care readings as high as 470. Her continued hospitalization and combined respiratory, nutritional, neurologic, cardiovascular, mobility, and wound-care needs underscore the disconnect between her documented clinical condition, her treating physicians' recommendation for LTCH care, and Aetna's determination that her needs could be met at a lower level of care.

* * *

84. Taken together, these patients' experiences demonstrate that Aetna's denials are not isolated errors or reasonable disagreements concerning individual requests for preauthorization of LTCH admission. Rather, they reflect a systematic, undisclosed, and financially driven anti-LTCH policy. Through this policy, Aetna wholly disregards patients' documented medical conditions, treatment needs, and

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realistic discharge options. This is the case even where patients remain ventilator-dependent, require multiple forms of intensive treatment, or continue to receive hospital-level care following Aetna's denials. Aetna's anti- LTCH policy prevents or delays critically ill patients from receiving medically necessary LTCH care, prolongs their hospitalizations in short-term acute care facilities, and exposes patients to serious risks of clinical deterioration, infection, functional decline, and other adverse outcomes.

Harm to Select's Business and Goodwill

85. Aetna's anti-LTCH policy also threatens irreparable harm to Select's business. Select's patient population derives largely from referrals from physicians in hospitals and other clinical settings who, in their medical judgment, discharge their patients to a long-term acute care hospital such as Select where they determine that an LTCH setting is the most appropriate level of care for the patient.

86. However, Aetna's anti-LTCH policy has discouraged many physicians from referring Aetna's Members to Select, realizing that such referrals will be futile because Aetna sees no value in Select's LTCHs and will inevitably refuse to preauthorize their patients' admissions to Select's LTCHs. As long as Aetna maintains its anti-LTCH policy, physicians will continue to be dissuaded from referring their patients who are Aetna's members to Select's LTCHs.

87. The downward trend among physicians who have declined to refer patients to Select as a result of its anti-LTCH policy, in turn, has eroded, and

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threatens to continue to erode, Select's reputation and standing in the medical community, and the public at large.

88. Indeed, as Aetna's anti-LTCH policy causes physician referrals to diminish, the medical community, and the public at large, will inevitably begin to conclude that Select's LTCHs are not a viable treatment option for patients, even though LTCHs have long been recognized as medically necessary for patients in need of hospital-level care for extended periods of time following discharge from a general acute-care hospital.

89. Thus, if allowed to continue, Aetna's anti-LTCH policy will cause irreparable harm to Select's reputation and goodwill, which will be impossible to calculate or remedy with monetary damages.

COUNT I
Breach of Contract

90. Plaintiff incorporates the foregoing paragraphs by reference as if set forth at length herein.

91. The Agreement is a valid, binding, and enforceable contract between Select and Aetna.

92. Under the Agreement and Applicable Law incorporated therein, Aetna is required to apply the applicable Medicare requirements when adjudicating requests for preauthorization of LTCH admission. Exhibit A at § 2.1(c).

93. Select has fully or substantially performed its obligations under the Agreement, including by remaining willing and available to treat Aetna's Medicare Members at its LTCHs.

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94. However, Aetna has breached, and continues to breach, the Agreement by instituting and maintaining an undisclosed but very real anti-LTCH policy, by which it systematically denies preauthorization requests for the admission of Aetna's Medicare Members to Select's LTCHs.

95. Aetna's anti-LTCH policy violates Aetna's contractual obligation under Section 2.1(c) of the Agreement to remain in material compliance with Applicable Law. Specifically, Aetna has applied criteria and practices that are more restrictive than the Traditional Medicare requirements incorporated into the Agreement, including 42 U.S.C. § 1395w-22(a)(1)(A), (B)(i) and 42 C.F.R. §§ 422.101(a), 422.101(b)(2), 422.101(b)(6), and 412.3(d)(1).

96. As a direct and proximate result of Aetna's continuing breaches of the Agreement, Select has suffered, and will continue to suffer, immediate and irreparable harm for which there is no adequate remedy at law.

97. Select's injuries are irreparable in several respects. First, Aetna's anti-LTCH policy prevents or delays Aetna's Medicare Members, many of whom are critically ill patients requiring hospital-level care that cannot safely be delivered in a less intensive setting, from receiving medically necessary LTCH care.

98. Second, through its anti-LTCH policy, Aetna threatens to damage Select's reputation in the communities its LTCHs serve by sending the message to Aetna's Medicare Members that the much-needed services that Select's LTCHs provide are not medically necessary, thereby eroding the goodwill that Select

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reasonably expected by entering into its Agreement with Aetna and participating in Aetna's network of participating providers.

99. Finally, monetary damages are inadequate because Aetna's breaches are continuing and systemic. Select is contractually required to provide medically necessary Covered Services to Aetna's Members. Exhibit A at § 1.1(a). Yet, through its anti-LTCH policy, Aetna continues to systematically deny preauthorization requests for admission of Medicare Members requiring medically necessary care to Select's LTCHs. A retrospective damages award would not stop Aetna's anti-LTCH policy, and it would not prevent Aetna from continuing to breach the Agreement.

100. Aetna is likely to continue its anti-LTCH policy absent injunctive relief. Aetna's practices are ongoing, and its dispute-resolution mechanisms have not remedied the systematic denials, notwithstanding Select's exhaustion of the appeals procedures provided under the Agreement.

101. An order directing Aetna to perform its contractual obligations is an appropriate remedy and the only remedy that is adequate, given the irreparable harm that Aetna's conduct has caused and threatens to continue to cause. Aetna's anti-LTCH policy directly impacts the medically necessary care provided to Aetna's Medicare Members, many of whom are critically ill patients requiring hospital-level care that cannot safely be delivered in a less intensive setting.

102. Moreover, through its anti-LTCH policy, Aetna threatens to damage Select's reputation in the communities its LTCHs serve by sending the message to

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Aetna's Medicare Members that the much-needed services that Select's LTCHs provide are not medically necessary.

103. Therefore, Select is entitled to an order of specific performance directing Aetna to rescind its anti-LTCH policy and instead, adjudicate requests for preauthorization of admission to Select's Pennsylvania LTCHs in accordance with the Agreement and Applicable Law, and otherwise comply in full with its obligations under the Agreement.

104. Injunctive relief is therefore necessary to remedy Aetna's ongoing breaches of the Agreement and to prevent further irreparable harm to Select.

WHEREFORE, Select respectfully requests that judgment be entered against Aetna for:

(a) An order directing Aetna to rescind its anti-LTCH policy and any other policy for denying preauthorization requests for admission to Select's LTCHs in violation of Applicable Law;

(b) An order directing specific performance of Aetna's contractual and statutory obligations under the Agreement and Applicable Law, including its obligation to arrange for medically necessary LTCH services through the authorization of qualifying Aetna Medicare Members' admissions to Select's Pennsylvania LTCHs;

(c) Plaintiff's reasonable attorneys' fees, expenses and costs to the extent permitted by law;

(d) Such other relief as this Court deems just and proper.

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October 2, 2026

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that this filing complies with the provisions of the *Public Access Policy of the Unified Judicial System of Pennsylvania: Case Records of the Appellate and Trial Courts* that require filing confidential information and documents differently than non-confidential information and documents.

October 2, 2026 /s/David R. Fine

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VERIFICATION

I, Thomas P. Mullin, a duly authorized representative of Select Medical Corporation, verify that the statements in the foregoing Complaint are true and correct to the best of my knowledge, information, and belief. This verification is made subject to the penalties of 18 Pa.C.S. § 4904 relating to unsworn falsification to authorities.

Date: 10/2/2026

Signed by:
Thomas P. Mullin
C04BB3B2BD17402...

Thomas P. Mullin
Chief Executive Officer

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EXHIBIT B

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Case Number: 2026-CV-02514

Department of Health and Human Services

Office of Inspector General

Office of Evaluation and Inspections

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

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HHS Office of Inspector General
HIGHLIGHTS

June 2026 | OEI-09-24-00330

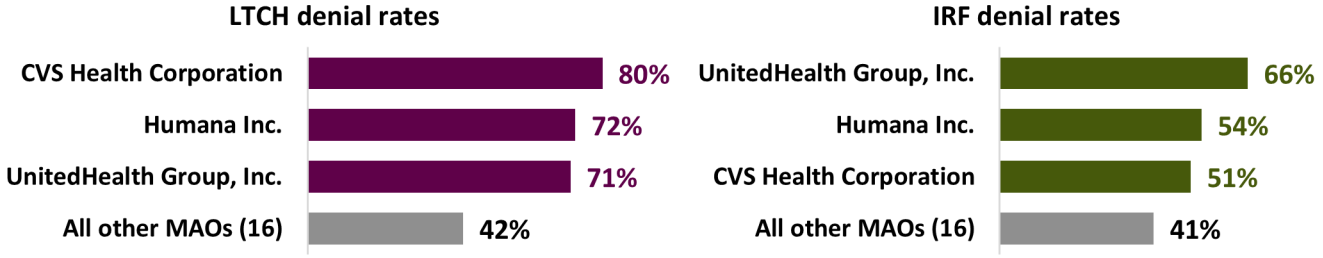
The Three Largest Medicare Advantage Organizations Denied Requests for Long-Term Acute Care and Inpatient Rehabilitation at Some of the Highest Rates

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.

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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]

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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).

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FINDINGS

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

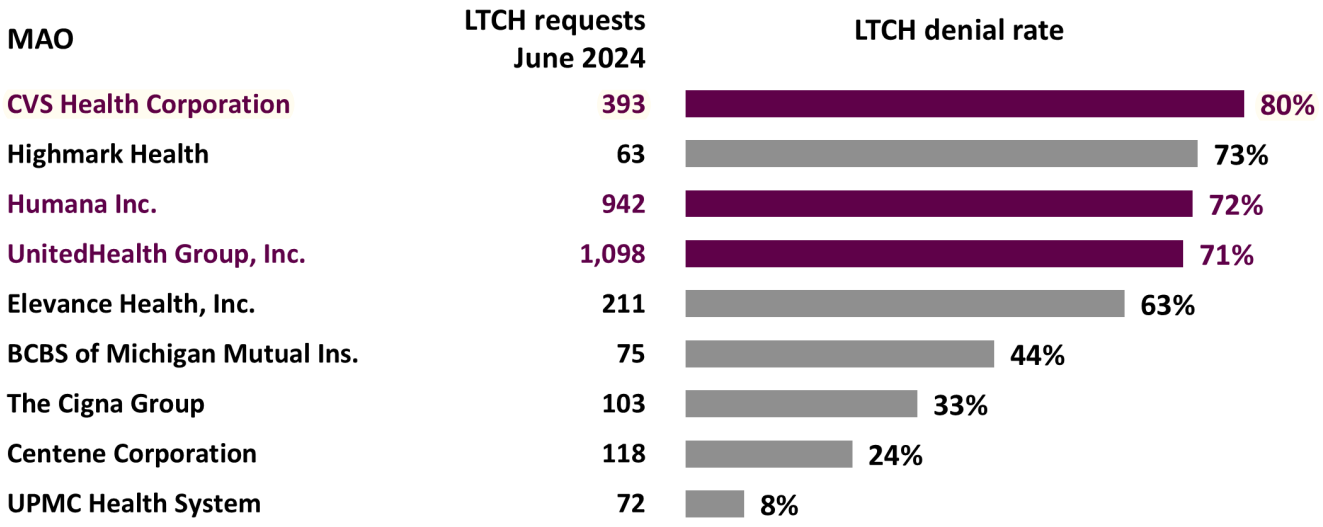
In June 2024, the 19 MAOs in this review denied almost two-thirds of requests for LTCH admission (approximately 2,100 of 3,200 requests) and denied more than half of requests for IRF admission (approximately 10,500 of 19,400 requests).

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



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

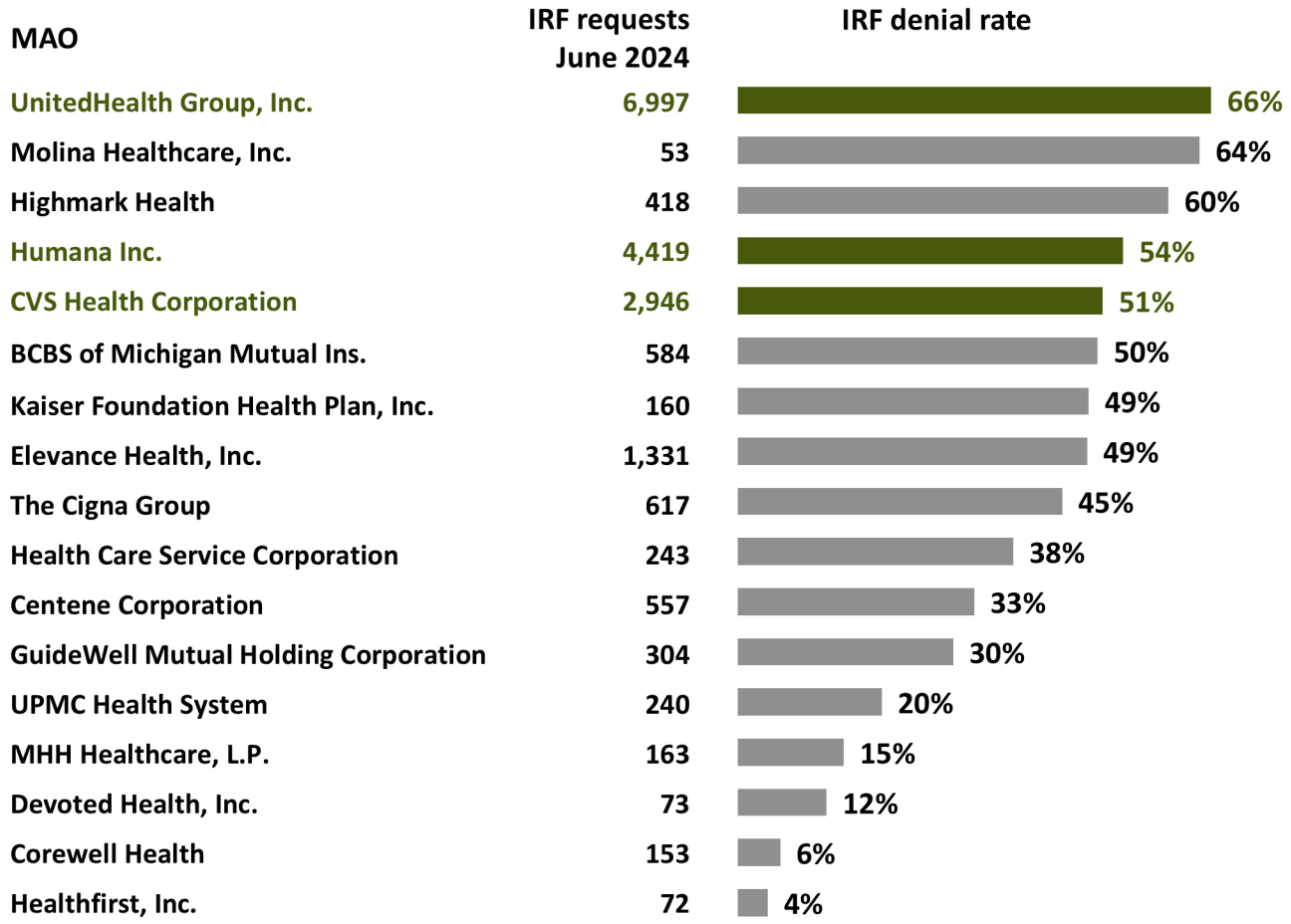
Note: CVS Health Corporation is the parent company of Aetna.

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

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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

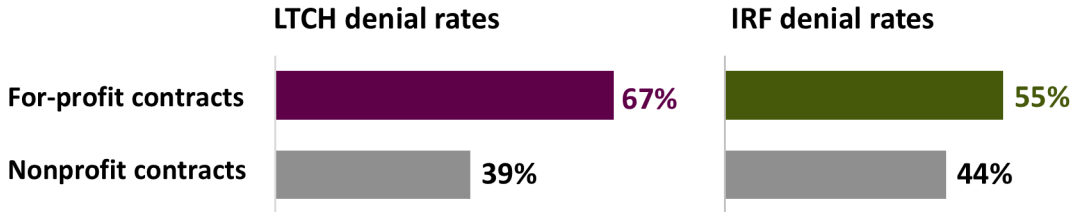
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policies or performance, such as how they interpret or apply coverage criteria. In future work, OIG will conduct an in-depth review of a sample of case files to examine MAOs' processes for reviewing prior authorization requests for post-acute care.[21]

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]

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

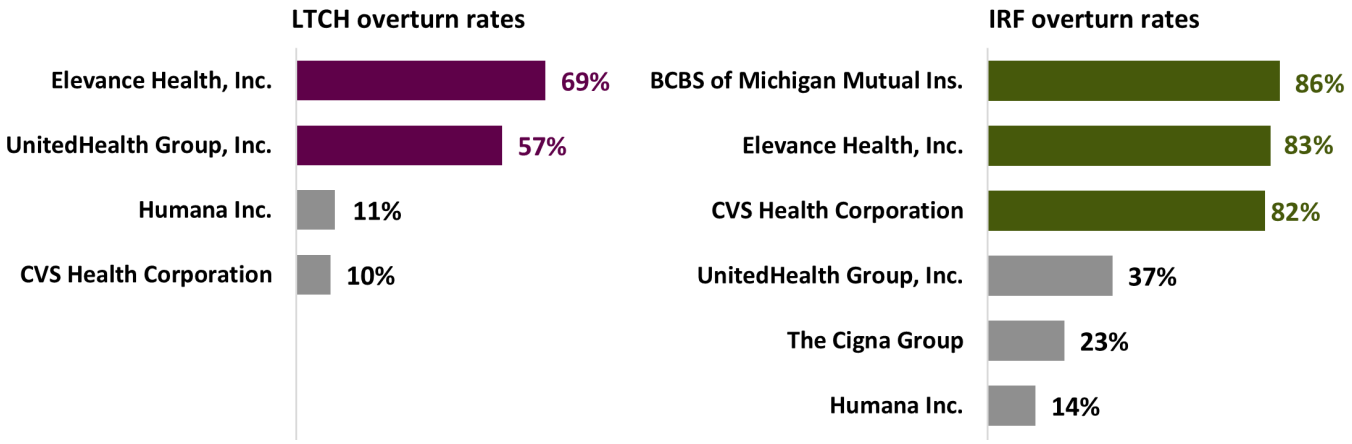
When enrollees appealed, MAOs overturned 36 percent of denials for LTCH admission (272 of 754 appeals) and 43 percent of denials for IRF admission (1,406 of 3,295 appeals).

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

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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

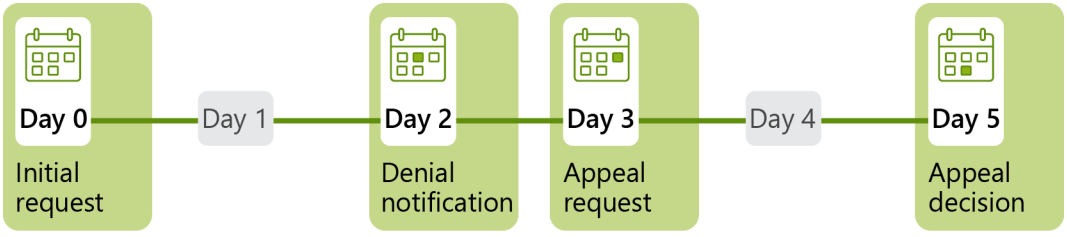
Given the relatively high rates of prior authorization denials for LTCH and IRF requests, the appeals process is an important safeguard to help ensure that patients have access to needed services. Enrollees and providers appealed around one-third of requests for LTCH and IRF admissions that MAOs denied (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

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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]

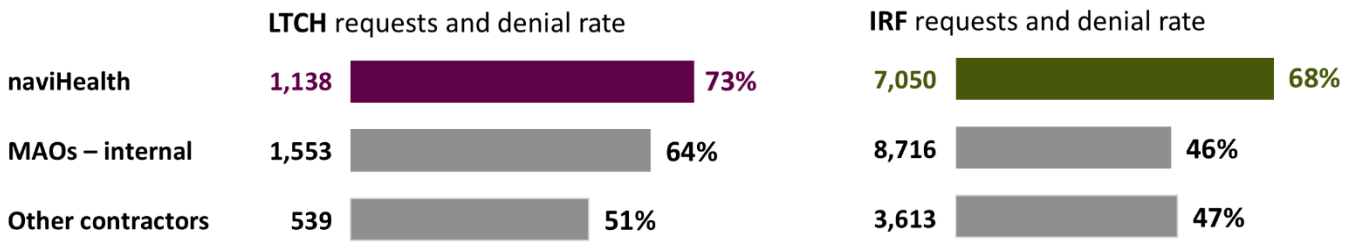
Some contractors were more likely to deny LTCH and IRF requests than MAOs that processed requests internally; many contractor denials were later overturned by MAOs

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

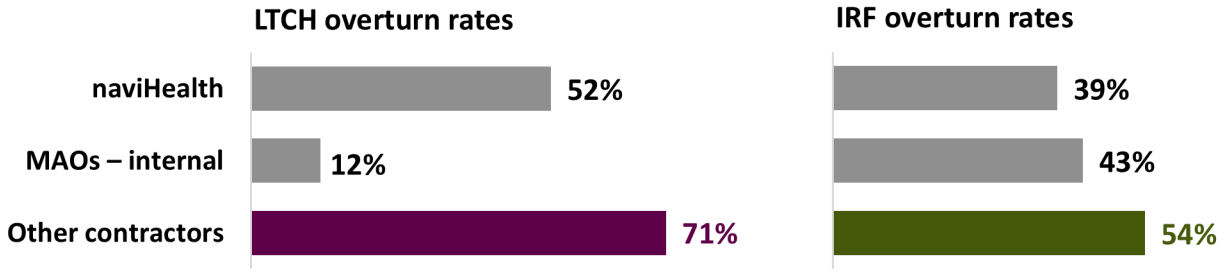
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contractor Carelon also had higher LTCH and IRF denial rates than MAOs that reviewed requests internally, but it processed far fewer requests than naviHealth (see Appendix E for denial and overturn rates by contractor). Large variation in denial rates 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.

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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]

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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.

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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.

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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.

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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

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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

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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Appendix G: Agency Comments

CMS's official comments begin on the next page.

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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

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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.

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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.

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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.

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[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.

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[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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Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

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U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov

EXHIBIT 2

Wolters Kluwer

CT Corporation
Service of Process Notification
10/09/2026
CT Log Number 553614574

Service of Process Transmittal Summary

TO: David Scott, Paralegal Consumer Litigation Team
Aetna Inc
151 Farmington Ave
Hartford, CT 06156-0002

RE: **Process Served in Pennsylvania**

FOR: Aetna Network Services LLC (Domestic State: CT)

ENCLOSED ARE COPIES OF LEGAL PROCESS RECEIVED BY THE STATUTORY AGENT OF THE ABOVE COMPANY AS FOLLOWS:

TITLE OF ACTION:	Select Medical Corporation vs. AETNA NETWORK SERVICES LLC
CASE #:	None Specified
NATURE OF ACTION:	Insurance Litigation
PROCESS SERVED ON:	C T Corporation System, Harrisburg, PA
DATE/METHOD OF SERVICE:	By Traceable Mail on 10/09/2026
JURISDICTION SERVED:	Pennsylvania
ACTION ITEMS:	CT has retained the current log, Retain Date: 10/09/2026, Expected Purge Date: 10/14/2026 Image SOP Email Notification, Desiree Beatty beattyd@aetna.com Email Notification, David Scott ScottD4@aetna.com Email Notification, Kim Lees kimberly.lees@cvshealth.com
REGISTERED AGENT CONTACT:	C T Corporation System 600 N. 2nd Street, Suite 401 Harrisburg, PA 17101 8775647529 MajorAccountTeam1@wolterskluwer.com

The information contained in this Transmittal is provided by CT for quick reference only. It does not constitute a legal opinion, and should not otherwise be relied on, as to the nature of action, the amount of damages, the answer date, or any other information contained in the included documents. The recipient(s) of this form is responsible for reviewing and interpreting the included documents and taking appropriate action, including consulting with its legal and other advisors as necessary. CT disclaims all liability for the information contained in this form, including for any omissions or inaccuracies that may be contained therein.

EXHIBIT 3

PROTHONOTARY OF DAUPHIN COUNTY

Antonio Carreno
Prothonotary

Autumn D. Heck
First Deputy

Jennifer L. Klinger
Second Deputy

Select Medical Corporation VS Aetna Network Services	**CASE NUMBER** 2026-CV-07514

Case Participants

Plaintiff
Select Medical Corporation

Defendant
Aetna Network Services

Attorney
Benjamin H McCoy, Esquire
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Attorney Relationships

Attorney	Plaintiff
David R Fine	Select Medical Corporation
Attorney	**Defendant**
Benjamin H McCoy, Esquire	Aetna Network Services

Prothonotary Docket Entries

Entry	Pages
10/05/2026 09:52 AM COMPLAINT	71
10/05/2026 09:52 AM CONFIDENTIAL DOCUMENT FORM ASSOCIATED WITH THE COMPLAINT, DATED OCTOBER 2, 2026	1
10/05/2026 09:52 AM CONFIDENTIAL DOCUMENT (EXHIBITS)	41
10/29/2026 04:54 PM BENJAMIN H. MACOY, ESQUIRE ENTERS APPEARANCE ON BEHALF OF AETNA NETWORK SERVICES, LLC	3
10/29/2026 04:54 PM STIPULATION TO EXTEND TIME TO RESPOND TO PLAINTIFF'S COMPLAINT	4

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Prothonotary Docket Entries

Total Number of Pages:	**120**

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Case Number: 2026-CV-07514

CONFIDENTIAL DOCUMENT FORM

Case Records Public Access Policy of the Unified Judicial System of Pennsylvania
204 Pa. Code § 213.81
www.pacourts.us/public-records

Select Medical Corporation
(Party name as displayed in case caption)

(not yet assigned)
Docket/Case No.

Vs.

Aetna Network Services, LLC
(Party name as displayed in case caption)

Court of Common Pleas/Dauphin Co.
Court

This form is associated with the pleading titled Complaint, dated October 2, 2026.

Pursuant to the *Case Records Public Access Policy of the Unified Judicial System of Pennsylvania*, the Confidential Document Form shall accompany a filing where a confidential document is required by law, ordered by the court, or is otherwise necessary to effect the disposition of a matter. This form shall be accessible to the public, however the documents attached shall not be publicly accessible, except as ordered by a court. The documents attached will be available to the parties, counsel of record, the court, and the custodian. **Please only attach documents necessary for the purposes of this case.** Complete the entire form and check all that apply. This form and any additional pages must be served on all unrepresented parties and counsel of record.

Type of Confidential Document	Paragraph, page, etc. where the confidential document is referenced in the filing:
☐ Financial Source Documents	
☐ Tax Returns and schedules	
☐ W-2 forms and schedules including 1099 forms or similar documents	
☐ Wage stubs, earning statements, or other similar documents	
☐ Credit card statements	
☐ Financial institution statements (e.g., investment/bank statements)	
☐ Check registers	
☐ Checks or equivalent	
☐ Loan application documents	
☐ Minors' educational records	
☐ Medical/Psychological records	
☐ Children and Youth Services' records	
☐ Marital Property Inventory and Pre-Trial Statement as provided in Pa.R.C.P. No. 1920.33	
☐ Income and Expense Statement as provided in Pa.R.C.P. No. 1910.27(c)	
☒ Agreements between the parties as used in 23 Pa.C.S. §3105	(confidential agreement)

I certify that this filing complies with the provisions of the *Case Records Public Access Policy of the Unified Judicial System of Pennsylvania* that require filing confidential information and documents differently than non-confidential information and documents.

Signature of Attorney or Unrepresented Party

10/02/26
Date

Name: David R Fine

Attorney Number: (if applicable) 66742

Address: K&L Gates/17 N. Second St.
Harrisburg, PA 17101

Telephone: (717) 231-5820

Email: david.fine@klgates.com

Rev. 7/2018

Dauphin County Prothonotary E-Filed - 29 Oct 2026 04:54:37 PM
Case Number: 2026-CV-07514

IN THE COURT OF COMMON PLEAS OF DAUPHIN COUNTY PENNSYLVANIA

SELECT MEDICAL CORPORATION, Plaintiff, v. AETNA NETWORK SERVICES, LLC, Defendant.	DOCKET NO. 2026-CV-07514

ENTRY OF APPEARANCE

TO THE PROTHONOTARY:

Kindly enter the appearance of Benjamin H. McCoy of the law firm of Stradley Ronon Stevens & Young, LLP, as counsel for Defendant Aetna Network Services, LLC in the above-captioned matter.

s/Benjamin H. McCoy

Benjamin H. McCoy
Stradley Ronon Stevens & Young, LLP
2005 Market St., Ste. 2600
Philadelphia, PA 19103
T: 215.564.8108
E: bmccoy@stradley.com
Attorneys for Defendant
Aetna Network Services, LLC

Date: October 29, 2026

Dauphin County Prothonotary E-Filed - 29 Oct 2026 04:54:37 PM
Case Number: 2026-CV-07514

CERTIFICATE OF COMPLIANCE

I certify that this filing complies with the provisions of the Public Access Policy of the Unified Judicial System of Pennsylvania: Case Records of the Appellate and Trial Courts that require filing confidential information and documents differently than non-confidential information and documents.

s/Benjamin H. McCoy
Benjamin H. McCoy
PA Attorney I.D. 314112
Stradley Ronon Stevens & Young, LLP
2005 Market St., Ste. 2600
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T: 215.564.8108
E: bmccoy@stradley.com
Attorneys for Defendant
Aetna Network Services, LLC

Date: October 29, 2026

Dauphin County Prothonotary E-Filed - 29 Oct 2026 04:54:37 PM
Case Number: 2026-CV-07514

CERTIFICATE OF SERVICE

I certify that on the date set forth below, I caused to be served a true and correct copy of the foregoing document by electronic mail to the following:

David R. Fine
K&L GATES LLP
17 North Second Street, 18th Floor
Harrisburg, Pennsylvania 17101
Phone: (717) 231-4500
David.Fine@klgates.com

Attorneys for Plaintiff
Select Medical Corporation

s/Benjamin H. McCoy
Benjamin H. McCoy
PA Attorney I.D. 314112
Stradley Ronon Stevens & Young, LLP
2005 Market St., Ste. 2600
Philadelphia, PA 19103
T: 215.564.8108
E: bmccoy@stradley.com
Attorneys for Defendant
Aetna Network Services, LLC

Date: October 29, 2026

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IN THE COURT OF COMMON PLEAS OF DAUPHIN COUNTY PENNSYLVANIA

SELECT MEDICAL CORPORATION, Plaintiff, v. AETNA NETWORK SERVICES, LLC, Defendant.	DOCKET NO. 2026-CV-07514

STIPULATION TO EXTEND TIME TO RESPOND TO PLAINTIFF'S COMPLAINT

IT IS HEREBY STIPULATED AND AGREED by and between counsel for Plaintiff Select Medical Corporation ("Plaintiff") and counsel for Defendant Aetna Network Services, LLC ("Aetna"), under Pa.R.C.P. 248, that the time within which Aetna may answer, move or otherwise respond to Plaintiff's Complaint is hereby extended up to and including **November 25, 2026**.

By: *s/David R. Fine*
David R. Fine
K&L Gates LLP
17 North Second St., 18th Flr.
Harrisburg, PA 17101
T: 717.231.4500
E: david.fine@klgates.com
Attorneys for Plaintiff
Select Medical Corporation

Date: October 29, 2026

By: *s/Benjamin H. McCoy*
Benjamin H. McCoy
Stradley Ronon Stevens & Young, LLP
2005 Market St., Ste. 2600
Philadelphia, PA 19103
T: 215.564.8108
E: bmccoy@stradley.com
Attorneys for Defendant
Aetna Network Services, LLC

Date: October 29, 2026

Dauphin County Prothonotary E-Filed - 29 Oct 2026 04:54:37 PM
Case Number: 2026-CV-07514

IN THE COURT OF COMMON PLEAS OF DAUPHIN COUNTY PENNSYLVANIA

SELECT MEDICAL CORPORATION, Plaintiff, v. AETNA NETWORK SERVICES, LLC, Defendant.	DOCKET NO. 2026-CV-07514

ORDER

AND NOW, this _____ day of _____, 2026, upon consideration of the partes' Stipulation to Extend Time to Answer Plaintiff's Complaint, it is hereby **ORDERED** that the deadline for Defendant Aetna Network Services, LLC to file its Answer to Plaintiff's Complaint is hereby extended up to and including November 25, 2026.

BY THE COURT:

_____

Dauphin County Prothonotary E-Filed - 29 Oct 2026 04:54:37 PM
Case Number: 2026-CV-07514

CERTIFICATE OF COMPLIANCE

I certify that this filing complies with the provisions of the Public Access Policy of the Unified Judicial System of Pennsylvania: Case Records of the Appellate and Trial Courts that require filing confidential information and documents differently than non-confidential information and documents.

s/Benjamin H. McCoy
Benjamin H. McCoy
PA Attorney I.D. 314112
Stradley Ronon Stevens & Young, LLP
2005 Market St., Ste. 2600
Philadelphia, PA 19103
T: 215.564.8108
E: bmccoy@stradley.com
Attorneys for Defendant
Aetna Network Services, LLC

Date: October 29, 2026

Dauphin County Prothonotary E-Filed - 29 Oct 2026 04:54:37 PM
Case Number: 2026-CV-07514

CERTIFICATE OF SERVICE

I certify that on the date set forth below, I caused to be served a true and correct copy of the foregoing document by electronic mail to the following:

David R. Fine
K&L GATES LLP
17 North Second Street, 18th Floor
Harrisburg, Pennsylvania 17101
Phone: (717) 231-4500
David.Fine@klgates.com

Attorneys for Plaintiff
Select Medical Corporation

s/Benjamin H. McCoy
Benjamin H. McCoy
PA Attorney I.D. 314112
Stradley Ronon Stevens & Young, LLP
2005 Market St., Ste. 2600
Philadelphia, PA 19103
T: 215.564.8108
E: bmccoy@stradley.com
Attorneys for Defendant
Aetna Network Services, LLC

Date: October 29, 2026

EXHIBIT 4

IN THE COURT OF COMMON PLEAS OF DAUPHIN COUNTY PENNSYLVANIA

SELECT MEDICAL CORPORATION, Plaintiff, v. AETNA NETWORK SERVICES, LLC, Defendant.	DOCKET NO. 2026-CV-07514

NOTICE OF FILING OF NOTICE OF REMOVAL

TO: Prothonotary, Court of Common Pleas
of Dauphin County, Pennsylvania
Dauphin County Courthouse
101 Market St.
Harrisburg, PA 17101

PLEASE TAKE NOTICE that on November 6, 2026, Defendant Aetna Network Services, LLC ("Aetna"), by and through its attorneys, Stradley Ronon Stevnes & Young, LLP, electronically filed a Notice of Removal in the United States District Court for the Middle District of Pennsylvania pursuant to 28 U.S.C. § 1446, to remove the above-captioned action from the Court of Common Pleas of Dauphin County, Pennsylvania, Docket No. 2026-CV-07514, to the United States District Court for the Middle District of Pennsylvania.

PLEASE TAKE FURTHER NOTICE that this Notice of Filing is given under the provisions of 28 U.S.C. § 1446(d). Accompanying this Notice as **Exhibit A** is a copy of the Notice of Removal so filed.

s/Benjamin H. McCoy
Benjamin H. McCoy
Stradley Ronon Stevens & Young, LLP
2005 Market St., Ste. 2600
Philadelphia, PA 19103
T: 215.564.8108
E: bmccoy@stradley.com
Attorneys for Defendant
Aetna Network Services, LLC

Date: November 6, 2026

CERTIFICATE OF SERVICE

The undersigned hereby certifies that, on the date set forth below, a true and correct copy of the foregoing Notice of Filing of Notice of Removal was caused to be served upon the following via the Court's electronic filing notification:

David R. Fine
K&L Gates LLP
17 North Second St., 18th Flr.
Harrisburg, PA 17101
david.fine@klgates.com
Attorneys for Plaintiff
Select Medical Corporation

s/Benjamin H. McCoy
Benjamin H. McCoy

Date: November 6, 2026

JS 44 (Rev. 03/24)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

Select Medical Corporation

(b) County of Residence of First Listed Plaintiff Cumberland
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

David R. Fine, K & L Gates LLP, 17 N. Second St., 18th Flr., Harrisburg, PA 17101, 717-231-4500

DEFENDANTS

Aetna Network Services, LLC

County of Residence of First Listed Defendant
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

Benjamin McCoy, Stradley Ronon Stevens & Young LLP, 2005 Market St., Ste. 2600, Philadelphia, PA, 215-564-8108

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☒ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

INTELLECTUAL PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

- ☐ 1 Original Proceeding
- ☒ 2 Removed from State Court
- ☐ 3 Remanded from Appellate Court
- ☐ 4 Reinstated or Reopened
- ☐ 5 Transferred from Another District *(specify)*
- ☐ 6 Multidistrict Litigation - Transfer
- ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
28 U.S.C. § 1442(a)(1)

Brief description of cause:
Medicare/Medicare Advantage dispute

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:

JURY DEMAND: ☐ Yes ☒ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
11/06/2026

SIGNATURE OF ATTORNEY OF RECORD
s/Benjamin H. McCoy

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) Plaintiffs-Defendants. Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) County of Residence. For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) Attorneys. Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. Jurisdiction. The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below**; NOTE: federal question actions take precedence over diversity cases.**)

III. Residence (citizenship) of Principal Parties. This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. Nature of Suit. Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. Origin. Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statute.

VI. Cause of Action. Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service.

VII. Requested in Complaint. Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. Related Cases. This section of the JS 44 is used to reference related cases, if any. If there are related cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.