

# Improve Accountability for Medicare Advantage Plans



**Congress should pass the *Medicare Advantage Improvement Act (H.R. 8375 / S. 4384)* to strengthen oversight of Medicare Advantage plans and ensure seniors receive timely, medically necessary care.**

## **i Background**

Medicare Advantage (MA) plans now covers more than half of all Medicare beneficiaries. This increased penetration and enrollment means MA organizations play a growing role in ensuring that seniors have access to medically necessary services and that physicians are paid for the care they provide.

Unfortunately, while the MA program offers flexibility and supplemental benefits, persistent problems with prior authorization delays, inappropriate care denials, and payment practices have increasingly interfered with patient access to care and clinician decision-making.

Family physicians report that MA plan requirements frequently delay or disrupt needed services, undermine continuity of care, and impose substantial administrative burdens that take time away from patient care.

## **i Legislative Solution**



The ***Medicare Advantage Improvement Act (H.R. 8375 / S. 4384)*** addresses these challenges by establishing clear, enforceable standards for prior authorization, medical necessity determinations, transparency, and payment practices in MA. This bipartisan bill is led in the House by Drs. John Joyce (R-PA) and Kim Schrier (D-WA) and in the Senate by Senators Roger Marshall (R-KS) and Sheldon Whitehouse (D-RI).

Specifically, the legislation would make the following reforms:

- Require MA plans to make standard prior authorization decisions within 72 hours and expedited decisions within 24 hours, improving timely access to care.
- Direct CMS to require real-time authorization for routine, low-risk, and high-volume services.
- Prevent MA plans from applying medical necessity criteria that are more restrictive than traditional Medicare and require determinations to be made by qualified clinicians.
- Prohibit retroactive claim denials or downcoding after services have been prior authorized, except in cases of fraud or clear error.
- Requires 100% of claims for previously authorized services to be paid promptly and applies prompt payment protections for both in- and out-of-network physicians to ensure they are paid reliably for authorized services.
- Require public reporting of prior authorization and compliance data and strengthen accountability through oversight and financial penalties for noncompliant plans.

**80%**

**The percent of denied prior authorization requests that MA plans overturned upon appeal.**

Other research and annual audits conducted by the Centers for Medicare and Medicaid Services (CMS) have also found that MA plans have persistently and inappropriately denied payment to physicians and other clinicians for services that met both Medicare coverage and billing requirements.