

Section 1 – Short Title

- Officially names the law the “**Medicare Advantage Improvement Act of 2025.**”
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Section 2 – Improving Access to Timely Care for Enrollees

This section significantly reforms **prior authorization** and **coverage determination** processes in Medicare Advantage (MA) plans.

A. Reducing Response Timeframes

- **Standard determinations** must be completed within **72 hours** (down from current longer timeframes).
- **Expedited requests** must be completed within **24 hours**.
- Extensions (up to 7 days) allowed only in limited, beneficiary-protective situations.
- The Secretary of HHS can revise deadlines after 2030.

B. Transparency in Prior Authorization

- Starting in 2028, MA plans must publish prior authorization data at the **plan, parent organization, and provider/service category level**.
- Data must be downloadable and accessible for research and oversight.

C. Real-Time Authorization for Certain Services

- Requires MA plans to adopt **real-time, automated approval systems** integrated with electronic health records (EHRs).
- CMS will annually publish a list of services that must use real-time approvals (e.g., routine, low-risk, or high-volume services).
- Quarterly reporting and public posting of approval, denial, appeal, and complaint data.

D. Prohibition on Re-Authorizations During Treatment

- If a service is already authorized, MA plans cannot require new authorizations for **clinically necessary modifications or extensions** during treatment.
- Plans may still require **post-service documentation**.

E. Reconsiderations Process Improvements

- Tightens deadlines for reconsideration appeals (14 days instead of 60).
- Requires MA plans to submit denial affirmations to **independent review entities** within 14 days.

- Independent reviewers must allow beneficiaries and providers to submit supporting evidence.
 - Sets strict deadlines for independent decisions (ranging from 24 hours to 30 days depending on service type).
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Section 3 – Ensuring Appropriate Oversight of MA Plans

A. MAO Compliance Scoring & Accountability

- Establishes a new **compliance scoring program**:
 - Compliance assessed across categories like prior authorization, coverage criteria, payment timeliness, marketing, and retroactive denials.
 - Plans receive a **0–100 score**.
 - Compliance “tiers” determine payment penalties:
 - Tier 2: -1.0% payment reduction.
 - Tier 3: -1.5% reduction.
 - Tier 4: -2.0% reduction.
- Compliance scores and violations must be published online for transparency.

B. Expansion of the Star Ratings Program

- Adds a new “**Compliance and Coverage Protection Domain**” to the MA star rating system.
 - Measures compliance with federal coverage standards, patient protections, and prior authorization rules.
 - Heavier weighting applied to compliance scores compared to other quality measures.
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Section 4 – Guardrails on Retrospective Clawbacks

A. Prompt Payment for Authorized Services

- Requires **100% of claims** for previously authorized services to be paid promptly (not just 95%).
- Any claim with an authorization is automatically considered a “clean claim.”

B. Limits on Post-Authorization Denials

- MA plans cannot deny coverage or downgrade codes after prior authorization was granted—unless there’s fraud or clear error.

C. Restrictions on Third-Party Review Entities

- Bans payment-denial arrangements tied to **volume of denials**.
 - Prohibits automated denial algorithms for post-payment reviews.
 - Requires independent, transparent audit protocols.
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Section 5 – Coverage and Medical Necessity Criteria

A. Codification of the “Two-Midnight Rule”

- MA plans must apply Medicare’s existing **two-midnight benchmark and presumption** rules for inpatient admissions.

B. Alignment with Fee-for-Service Standards

- MA plans may not impose **stricter coverage or medical necessity criteria** than traditional Medicare.
- Applies to rehabilitation hospitals, long-term care hospitals, and all medically necessary services.
- Requires reviews to be conducted by **qualified clinicians with expertise**.

C. Transparency of Coverage Criteria

- If no national or local Medicare coverage guidance exists, MA plans must:
 - Publish their **coverage criteria online**.
 - Submit coverage determinations to CMS for oversight.
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Section 6 – Eliminating Inefficiencies in Administrative Processing

A. Extending Prompt Payment Requirements

- Applies **prompt payment rules to both in-network and out-of-network providers**.
- Once deemed “clean,” a claim cannot later be reclassified unless CMS rules allow.

B. Automated Review and Payment

- Requires MA plans to use **automated systems** to pay for:
 - Authorized services.
 - Low-risk, routine services identified by CMS.
 - Manual review only allowed in suspected fraud cases.
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Section 7 – Network Adequacy Standards for Post-Acute Care Providers

- Beginning in 2028, MA plans must include **adequate access to inpatient rehab facilities and long-term care hospitals** as part of network adequacy compliance.
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Overall Significance of the Bill

The *Medicare Advantage Improvement Act of 2025* represents a **sweeping reform** aimed at:

- Protecting patients from unnecessary delays and denials.
- Standardizing coverage criteria between MA and traditional Medicare.
- Increasing transparency in prior authorization and compliance.
- Penalizing plans that fail to meet oversight and compliance benchmarks.
- Reducing administrative burdens through real-time and automated systems.
- Strengthening patient access to post-acute care providers.

In short, the bill shifts MA plan oversight toward **faster, more transparent, patient-friendly processes**, while curbing cost-cutting practices that have drawn scrutiny from regulators and providers.