

119TH CONGRESS  
2D SESSION

# S. 4384

To amend title XVIII of the Social Security Act to provide for certain reforms under the Medicare Advantage program, and for other purposes.

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IN THE SENATE OF THE UNITED STATES

APRIL 27, 2026

Mr. MARSHALL (for himself and Mr. WHITEHOUSE) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend title XVIII of the Social Security Act to provide for certain reforms under the Medicare Advantage program, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

3       **SECTION 1. SHORT TITLE.**

4       This Act may be cited as the “Medicare Advantage  
5       Improvement Act of 2026”.

6       **SEC. 2. IMPROVING ACCESS TO TIMELY CARE FOR ENROLL-**  
7       **EES OF MEDICARE ADVANTAGE PLANS.**

8       (a) REDUCING TIMEFRAMES FOR MEDICARE ADVAN-  
9       TAGE ORGANIZATIONS TO RESPOND TO CERTAIN AU-  
10      THORIZATION REQUESTS.—

(1) STANDARD ORGANIZATION DETERMINATIONS.—Section 1852(g)(1) of the Social Security Act (42 U.S.C. 1395w–22(g)(1)) is amended—

(A) in subparagraph (A), in the second sentence, by inserting “subparagraph (C) and” after “Subject to”;

(B) in subparagraph (B), by striking “Such a determination” and inserting “A determination described in subparagraph (A) or (C)”;

(C) by adding at the end the following new subparagraph:

“(C) REQUIRED TIMEFRAMES FOR RESPONSES TO CERTAIN AUTHORIZATION REQUESTS.—

“(i) IN GENERAL.—Subject to clause (ii) and paragraph (3)(B)(iii), the procedure established pursuant to subparagraph (A) by a Medicare Advantage organization offering an MA plan shall provide that in the case of a request made on or after January 1, 2028, for a specified authorization (as defined in clause (iii)) with respect to an individual enrolled under such plan, the Medicare Advantage organization must

1 notify the individual (and the provider of  
 2 services or supplier involved, as appro-  
 3 priate) of the determination regarding such  
 4 request as expeditiously as the health con-  
 5 dition of the individual requires, but, sub-  
 6 ject to clause (iv), not later than 72 hours  
 7 after receipt of the request.

8 “(ii) EXTENSIONS.—Subject to clause  
 9 (iv), a Medicare Advantage organization  
 10 offering an MA plan may extend the dead-  
 11 line applied under clause (i) or the dead-  
 12 line applied under paragraph  
 13 (3)(B)(iii)(II), as applicable, with respect  
 14 to a determination regarding a specified  
 15 request for an individual enrolled under  
 16 the MA plan, by up to 7 calendar days if—

17 “(I) the individual requests the  
 18 extension;

19 “(II) the extension is needed for  
 20 purposes of obtaining additional rel-  
 21 evant medical evidence from a pro-  
 22 vider of services or supplier that does  
 23 not have a contract with the MA orga-  
 24 nization to furnish items and services

1 to individuals enrolled under the MA  
2 plan; or

3 “(III) the extension is in the in-  
4 dividual’s interest and is justified by  
5 reason of extraordinary, exigent, or  
6 other nonroutine circumstances that  
7 are not within the reasonable control  
8 of the MA organization (as deter-  
9 mined by the Secretary).

10 “(iii) SPECIFIED AUTHORIZATION DE-  
11 FINED.—For purposes of this part, the  
12 term ‘specified authorization’—

13 “(I) means, with respect to an  
14 individual enrolled under an MA plan  
15 offered by a Medicare Advantage or-  
16 ganization, an authorization of cov-  
17 erage or payment for an item or serv-  
18 ice through—

19 “(aa) a prior authorization  
20 or preservice determination of  
21 coverage or payment; or

22 “(bb) a concurrent deter-  
23 mination made while the indi-  
24 vidual is receiving the relevant  
25 item or service; and

1 “(II) includes an authorization  
 2 for a transfer of the individual be-  
 3 tween hospitals or between a hospital  
 4 and post-acute care facility.

5 “(iv) SECRETARIAL AUTHORITY.—  
 6 With respect to requests for a specified au-  
 7 thorization made on or after January 1,  
 8 2030, in carrying out clause (i) and (ii)  
 9 and paragraph (3)(B)(iii)(II), the Sec-  
 10 retary may specify through notice and  
 11 comment rulemaking a deadline other than  
 12 the deadline specified in the relevant clause  
 13 or paragraph.”.

14 (2) EXPEDITED ORGANIZATION DETERMINA-  
 15 TIONS.—Section 1852(g)(3)(B)(iii) of the Social Se-  
 16 curity Act (42 U.S.C. 1395w–22(g)(3)(B)(iii)) is  
 17 amended—

18 (A) by striking “TIMELY RESPONSE.—In  
 19 cases described” and inserting: “TIMELY RE-  
 20 SPONSE.—

21 “(I) IN GENERAL.—Subject to  
 22 subclause (II), in cases described”;  
 23 and

24 (B) by adding at the end the following new  
 25 subclause:

1                   “(II)   REDUCING   EXPEDITED  
2                   TIMEFRAMES   FOR   RESPONSES   TO  
3                   CERTAIN   AUTHORIZATION   RE-  
4                   QUESTS.—Subject   to   paragraph  
5                   (1)(C)(ii),   in   cases   described   in  
6                   clauses (i) and (ii) that are related to  
7                   an expedited determination for a spec-  
8                   ified authorization (as defined in  
9                   paragraph (1)(C)(iii)) for which a re-  
10                  quest is submitted on or after Janu-  
11                  ary 1, 2028, the Medicare Advantage  
12                  organization shall notify the enrollee  
13                  (and the physician involved, as appro-  
14                  priate) of the determination under  
15                  time limitations established by the  
16                  Secretary. Subject to paragraph  
17                  (1)(C)(iv), such notification shall be  
18                  made not later than 24 hours after  
19                  the receipt of the request for the de-  
20                  termination (or receipt of the informa-  
21                  tion necessary to make the determina-  
22                  tion).”.

23                  (3) IMPROVED TRANSPARENCY OF CERTAIN  
24                  PRIOR AUTHORIZATION INFORMATION ON THE MA  
25                  PLAN LEVEL.—Beginning with plan years beginning

1 on or after January 1, 2028, in carrying out the  
 2 provisions of section 422.122(c) of title 42, Code of  
 3 Federal Regulations (or any successor regulation),  
 4 the Secretary of Health and Human Services shall—

5 (A) require Medicare Advantage organiza-  
 6 tions to report prior authorization data de-  
 7 scribed in such section on the plan level and on  
 8 the Medicare Advantage organization parent  
 9 level in addition to the contract level;

10 (B) require Medicare Advantage organiza-  
 11 tions to report prior authorization data de-  
 12 scribed in such section in a manner that allows  
 13 comparison of such data based on provider and  
 14 service category; and

15 (C) in addition to making such data pub-  
 16 licly available, as described in such section,  
 17 make such data available in a downloadable for-  
 18 mat that is accessible for research purposes and  
 19 oversight and enforcement activities of the Sec-  
 20 retary.

21 (b) REAL-TIME AUTHORIZATION DECISIONS FOR  
 22 CERTAIN IDENTIFIED SERVICES.—Section 1852(g)(1) of  
 23 the Social Security Act (42 U.S.C. 1395w–22(g)(1)), as  
 24 amended by subsection (a), is further amended—

1           (1) in subparagraph (A), in the second sen-  
 2           tence, by striking “subparagraph (C) and” and in-  
 3           serting “subparagraphs (C) and (D) and”;

4           (2) in subparagraph (B), by striking “A deter-  
 5           mination described in subparagraph (A) or (C)” and  
 6           inserting “A determination described in subpara-  
 7           graph (A), (C), or (D)”;

8           (3) in subparagraph (C)(i), by striking “Subject  
 9           to clause (ii)” and inserting “Subject to clause (ii),  
 10          subparagraph (D),”; and

11          (4) by adding at the end the following new sub-  
 12          paragraph:

13                   “(D) REAL-TIME AUTHORIZATION DECI-  
 14                   SIONS FOR IDENTIFIED SERVICES.—

15                   “(i) IN GENERAL.—The procedure es-  
 16                   tablished pursuant to subparagraph (A)  
 17                   shall require that the Medicare Advantage  
 18                   organization has in place a mechanism and  
 19                   process through which, beginning January  
 20                   1, 2028, the organization provides a real-  
 21                   time determination, in accordance with this  
 22                   subparagraph, in response to any request  
 23                   for a specified authorization (as defined in  
 24                   subparagraph (C)(iii)) that is—



1 “(I) made with respect to an  
2 item or service identified on the most  
3 recent list published pursuant to  
4 clause (iii); and

5 “(II) submitted through certified  
6 EHR technology (as defined in section  
7 1848(o)(4)).

8 “(ii) REQUIREMENTS FOR REAL-TIME  
9 MECHANISM AND PROCESS.—The mecha-  
10 nism and process required under clause (i)  
11 shall—

12 “(I) include real-time tools capa-  
13 ble of providing immediate automated  
14 approvals;

15 “(II) provide for the integration  
16 of such tools in a manner that is  
17 interoperable with certified EHR tech-  
18 nology (as so defined) used by pro-  
19 viders of services and suppliers; and

20 “(III) enable immediate notifica-  
21 tion to the provider of services or sup-  
22 plier, as applicable, of determinations,  
23 including, in the case of a denial, noti-  
24 fication of any additional documenta-  
25 tion needed.

1 “(iii) ANNUAL PUBLICATION OF LIST  
2 OF IDENTIFIED SERVICES REQUIRING  
3 REAL-TIME AUTHORIZATION SUPPORT.—  
4 For purposes of this subparagraph, for  
5 each plan year beginning on or after Janu-  
6 ary 1, 2028, the Secretary shall annually  
7 establish through notice and comment rule-  
8 making a list identifying the following  
9 items and services:

10 “(I) Items and services for  
11 which, with respect to the previous  
12 plan year, at least 90 percent of re-  
13 quests for a specified authorization  
14 were approved across all Medicare Ad-  
15 vantage organizations.

16 “(II) Items and services that are  
17 clinically low-risk and routine, as de-  
18 fined by the Secretary through notice  
19 and comment rulemaking.

20 “(III) Items and services that the  
21 Secretary identifies, according to  
22 standards specified by the Secretary  
23 through notice and comment rule-  
24 making, as representative of signifi-  
25 cant service volume and administra-

1           tive burden for acquiring such a speci-  
2           fied authorization.

3           “(iv) IMPROVING TRANSPARENCY.—

4                   “(I) QUARTERLY MAO REPORTS  
5           TO CMS.—Beginning January 1,  
6           2028, and quarterly thereafter, each  
7           Medicare Advantage organization of-  
8           fering an MA plan shall submit to the  
9           Secretary (in a form and manner  
10          specified by the Secretary) informa-  
11          tion (presented by provider and serv-  
12          ice type) regarding real-time deter-  
13          minations made by the organization  
14          during the previous quarter pursuant  
15          to this subparagraph, including infor-  
16          mation on—

17                   “(aa) the number of real-  
18                  time determinations made during  
19                  the quarter, and the percentage  
20                  of all determinations made dur-  
21                  ing the quarter with respect to  
22                  an item or service identified on  
23                  the most recent list published  
24                  pursuant to clause (iii) that were  
25                  real-time determinations;

1 “(bb) the number and per-  
2 centage of real-time determina-  
3 tions made during such quarter  
4 that were approved;

5 “(cc) the number and per-  
6 centage of such determinations  
7 that were denied;

8 “(dd) the number and per-  
9 centage of such denied deter-  
10 minations that were appealed;

11 “(ee) the number and per-  
12 centage of such appealed deter-  
13 minations that were overturned;  
14 and

15 “(ff) the number and per-  
16 centage of provider complaints  
17 regarding the mechanism and  
18 process implemented by the  
19 Medicare Advantage organization  
20 pursuant to this subparagraph.

21 The information submitted pursuant  
22 to the previous sentence shall include  
23 such information and be provided in  
24 such a manner to enable comparison  
25 and analysis of such information on

1 the Medicare Advantage organization  
 2 level, Medicare Advantage parent or-  
 3 ganization level, and MA plan level.

4 “(II) PUBLIC AVAILABILITY OF  
 5 INFORMATION.—The Secretary shall  
 6 make information collected under sub-  
 7 clause (I) publicly available on the  
 8 internet website of the Centers for  
 9 Medicare & Medicaid Services.”.

10 (c) PROHIBITING CERTAIN AUTHORIZATION PROC-  
 11 ESSES FOR CERTAIN CLINICALLY NECESSARY CHANGES  
 12 AND EXTENSIONS.—Section 1852(d) of the Social Secu-  
 13 rity Act (42 U.S.C. 1395w–22(d)) is amended by adding  
 14 at the end the following new paragraph:

15 “(7) PROHIBITION ON REQUIRING CERTAIN AU-  
 16 THORIZATIONS.—Beginning January 1, 2028, in the  
 17 case that a Medicare Advantage organization offer-  
 18 ing an MA plan provides approval through a speci-  
 19 fied authorization (as defined in subsection  
 20 (g)(1)(C)(iii)) for an item or service to be furnished  
 21 to an individual enrolled in the plan by a provider  
 22 of services or supplier, if during the course of fur-  
 23 nishing such approved item or service the provider  
 24 of services or supplier determines that a modifica-  
 25 tion, extension, or adjustment to such item or serv-

1 ice is clinically necessary, the Medicare Advantage  
 2 organization may not require a specified authoriza-  
 3 tion (as defined in subsection (g)(1)(C)(iii)) to be re-  
 4 quested with respect to such item or service as so  
 5 modified, extended, or adjusted. Application of the  
 6 previous sentence shall not limit the authority of the  
 7 Medicare Advantage organization to require docu-  
 8 mentation or post-service notification of any such  
 9 modification, extension, or adjustment.”.

10 (d) IMPROVEMENTS TO THE RECONSIDERATIONS  
 11 PROCESS.—Section 1852(g) of the Social Security Act (42  
 12 U.S.C. 1395w–22(g)) is amended—

13 (1) in paragraph (2)—

14 (A) in subparagraph (A), by inserting “(or,  
 15 with respect to determinations made on or after  
 16 January 1, 2028, not later than 14 days)” after  
 17 “60 days”; and

18 (B) by adding at the end the following new  
 19 subparagraph:

20 “(C) RECONSIDERATIONS AFFIRMING DE-  
 21 NIALS OF COVERAGE.—If a reconsideration af-  
 22 firms (in whole or in part) a denial of coverage  
 23 (including an adverse organization determina-  
 24 tion under section 422.590 of title 42, Code of  
 25 Federal Regulations, or any successor regula-

tion) made on or after January 1, 2028, with respect to an individual enrolled in an MA plan offered by a Medicare Advantage organization, the Medicare Advantage organization shall submit to the independent, outside entity with a contract under paragraph (4) the case file and written explanation of the decision as expeditiously as the individual's health condition requires, but not later than 14 days after the date the Medicare Advantage organization received the request for the reconsideration.”; and (2) in paragraph (4)—

(A) by striking “COVERAGE DENIALS.—The Secretary shall contract with” and inserting: “COVERAGE DENIALS.—

“(A) IN GENERAL.—The Secretary shall contract with”; and

(B) by adding at the end the following new subparagraphs:

“(B) REQUIREMENTS.—In reviewing and resolving pursuant to subparagraph (A) a reconsideration of a determination of a Medicare Advantage organization made on or after January 1, 2028, with respect to an individual enrolled in an MA plan offered by the organiza-

tion, the independent, outside entity shall comply with each of the following requirements:

“(i) NOTICE AND OPPORTUNITY TO PROVIDE SUPPORTING DOCUMENTATION.—

The entity shall—

“(I) not later than 3 days after the date of receipt of the relevant case file from the Medicare Advantage organization, submit to the individual, the representative of the individual (if applicable), and the provider of services or supplier furnishing (or ordering) the item or service that is the subject of the determination, a notification regarding the opportunity to submit documentation, including medical records, regarding medical necessity; and

“(II) provide a period of 7 days from the date of receipt of such notification for submission of any such documentation.

“(ii) DECISION TIMEFRAME.—After reviewing and considering all supporting documentation received before the end of



1 the 7-day period described in clause (i)(II),  
2 the entity shall issue its decision with re-  
3 spect to such reconsideration as expedi-  
4 tiously as the individual's health condition  
5 requires, but by not later than the applica-  
6 ble number of days specified in subpara-  
7 graph (C) after the last day of the 7-day  
8 period described in clause (i)(II).

9 “(C) APPLICABLE NUMBER OF DAYS.—For  
10 purposes of subparagraph (B)(ii), the applicable  
11 number of days specified in this subparagraph  
12 is—

13 “(i) 14 days, in the case of a request  
14 (other than with respect to an expedited  
15 reconsideration under paragraph (3)) for  
16 coverage of an item or service that is not  
17 a drug for which payment may be made  
18 under part B;

19 “(ii) 7 days, in the case of a request  
20 (other than with respect to an expedited  
21 reconsideration under paragraph (3)) for  
22 coverage of a drug for which payment may  
23 be made under part B;

24 “(iii) 30 days, in the case of a request  
25 (other than with respect to an expedited

1 reconsideration under paragraph (3)) for  
 2 payment of an item or service; and

3 “(iv) 24 hours, in the case of a re-  
 4 quest with respect to an expedited recon-  
 5 sideration under paragraph (3).”.

6 **SEC. 3. ENSURING APPROPRIATE OVERSIGHT OF MEDI-**  
 7 **CARE ADVANTAGE PLANS.**

8 (a) MAO COMPLIANCE SCORING AND ACCOUNT-  
 9 ABILITY PROGRAM.—Section 1853 of the Social Security  
 10 Act (42 U.S.C. 1395w–23) is amended by adding at the  
 11 end the following new subsection:

12 “(p) COMPLIANCE SCORING AND ENFORCEMENT.—

13 “(1) PAYMENT REDUCTIONS FOR MAOS IN NON-  
 14 COMPLIANCE WITH CERTAIN MA PROGRAM REQUIRE-  
 15 MENTS.—

16 “(A) IN GENERAL.—In the case of a Medi-  
 17 care Advantage organization with a contract  
 18 under this part that the Secretary determines,  
 19 in accordance with this subsection, to be within  
 20 a compliance tier specified in subparagraph (B)  
 21 for a performance period with respect to a plan  
 22 year beginning on or after January 1, 2028, the  
 23 Secretary shall reduce the total of the monthly  
 24 payments made for the plan year under section  
 25 1853(a)(1) to the Medicare Advantage organi-

1           zation with respect to each Medicare Advantage  
 2           plan offered by such organization by the appli-  
 3           cable percent specified under subparagraph (B)  
 4           with respect to the compliance tier.

5           “(B) APPLICABLE PERCENT SPECIFIED.—  
 6           For purposes of subparagraph (A), the applica-  
 7           ble percent specified under this subparagraph is  
 8           as follows:

9                   “(i) With respect to the compliance  
 10                  tier described in paragraph (5)(B), 1.0  
 11                  percent.

12                  “(ii) With respect to the compliance  
 13                  tier described in paragraph (5)(C), 1.5  
 14                  percent.

15                  “(iii) With respect to the compliance  
 16                  tier described in paragraph (5)(D), 2.0  
 17                  percent.

18           “(C) PERFORMANCE PERIOD.—For pur-  
 19           poses of this subsection, the Secretary shall es-  
 20           tablish a performance period (or periods) for  
 21           each plan year beginning on or after January 1,  
 22           2028. Such performance period (or periods)  
 23           shall begin and end prior to the beginning of  
 24           the plan year and be as close as possible to  
 25           such plan year. In this subsection, such per-

1           formance period (or periods) for a plan year  
2           shall be referred to as the performance period  
3           with respect to the plan year.

4           “(2) ESTABLISHMENT OF COMPLIANCE SCOR-  
5           ING AND ACCOUNTABILITY PROGRAM.—For purposes  
6           of this subsection, the Secretary shall establish a  
7           Medicare Advantage organization compliance scoring  
8           and accountability program (referred to under this  
9           subsection as the ‘MAO Compliance Program’)  
10          under which, for each Medicare Advantage organiza-  
11          tion with a contract under this part and each per-  
12          formance period with respect to a plan year begin-  
13          ning on or after January 1, 2028, the Secretary—

14               “(A) using the method established under  
15               paragraph (3)(A), shall assess the extent to  
16               which the Medicare Advantage organization is  
17               in compliance with requirements under this part  
18               applicable to each compliance category specified  
19               under paragraph (3)(B);

20               “(B) based on such assessments for each  
21               such compliance category, shall assign a total  
22               compliance score to the Medicare Advantage or-  
23               ganization, in accordance with paragraph (4);  
24               and

1 “(C) based on such total compliance score,  
2 shall assign the Medicare Advantage organiza-  
3 tion to a compliance tier described in paragraph  
4 (5).

5 “(3) ASSESSMENT METHOD.—

6 “(A) IN GENERAL.—Under the MAO Com-  
7 pliance Program, the Secretary shall establish  
8 through notice and comment rulemaking a  
9 method to assess, at the plan level, the extent  
10 to which each Medicare Advantage organization  
11 offering a Medicare Advantage plan is in com-  
12 pliance with requirements under this part appli-  
13 cable to each compliance category specified in  
14 subparagraph (B). Such method shall include  
15 the use of audit mechanisms, reporting require-  
16 ments, performance measures established or  
17 identified by the Secretary (such as applicable  
18 measures under the MA Program Compliance  
19 and Coverage Protection Domain described in  
20 section 1853(o)(8)), and such other methods as  
21 specified by the Secretary.

22 “(B) COMPLIANCE CATEGORIES.—

23 “(i) IN GENERAL.—Subject to clause  
24 (ii), under the MAO Compliance Program,

1 each of the following shall be a compliance  
2 category:

3 “(I) Compliance with timely and  
4 real-time specified authorization deci-  
5 sion-making requirements, including  
6 compliance with section 1852(d)(7)  
7 and paragraphs (1)(C), (1)(D), and  
8 (3)(B)(iii)(II) of section 1852(g).

9 “(II) Compliance with coverage  
10 criteria standards, including the re-  
11 quirements under section 1852(g)(7)  
12 and section 1852(a)(2)(D).

13 “(III) Compliance with prompt  
14 payment requirements, including com-  
15 pliance with section 1857(f).

16 “(IV) Compliance with restric-  
17 tions regarding improper retroactive  
18 denials and downgrades, including  
19 compliance with section 1852(g)(6)  
20 and section 1857(e)(7).

21 “(V) Compliance with marketing,  
22 enrollment, and beneficiary commu-  
23 nication requirements, including sub-  
24 part V of part 422 of title 42, Code

1 of Federal Regulations, or any suc-  
 2 cessor to such regulations.

3 “(VI) Compliance with other re-  
 4 quirements under this part, including  
 5 section 1852(g)(1)(E) and such other  
 6 requirements as specified by the Sec-  
 7 retary.

8 “(ii) UPDATES.—The Secretary may,  
 9 through notice and comment rulemaking,  
 10 revise the compliance categories described  
 11 in clause (i), including by specifying addi-  
 12 tional categories, removing categories, and  
 13 otherwise updating the requirements that  
 14 are included in any of such compliance cat-  
 15 egories.

16 “(4) SCORING METHODOLOGY.—Under the  
 17 MAO Compliance Program, the Secretary shall,  
 18 through notice and comment rulemaking, establish a  
 19 methodology to assign a total compliance score  
 20 (using a scoring scale of 0 to 100) to each Medicare  
 21 Advantage organization for the performance period  
 22 with respect to a plan year. Such total compliance  
 23 score shall be based on the assessment under para-  
 24 graph (3) of plan-level compliance with respect to  
 25 each compliance category described in subparagraph

1 (B) of such paragraph, with each such category re-  
2 ceiving equal weight (and, in the case of a Medicare  
3 Advantage organization offering more than one plan  
4 during the performance period, with each such as-  
5 sessment weighted by the number of individuals en-  
6 rolled under such plan during such period).

7 “(5) COMPLIANCE TIERS.—For each plan year  
8 beginning on or after January 1, 2028, the Sec-  
9 retary shall, based on the total compliance score as-  
10 signed pursuant to paragraph (4) to a Medicare Ad-  
11 vantage organization for the performance period  
12 with respect to such year, assign such Medicare Ad-  
13 vantage organization to one of the following compli-  
14 ance tiers, as follows:

15 “(A) Compliance tier one, consisting of  
16 Medicare Advantage organizations receiving a  
17 total score for the performance period of at  
18 least 90.

19 “(B) Compliance tier two, consisting of  
20 Medicare Advantage organizations receiving a  
21 total score for the performance period of at  
22 least 75 but not more than 89.

23 “(C) Compliance tier three, consisting of  
24 Medicare Advantage organizations receiving a



1 total score for the performance period of at  
2 least 60 but not more than 74.

3 “(D) Compliance tier four, consisting of  
4 Medicare Advantage organizations receiving a  
5 total score for the performance period of less  
6 than 60.

7 “(6) REVIEW.—The Secretary shall establish a  
8 process under which a Medicare Advantage organi-  
9 zation may seek a review of the total compliance  
10 score assigned to the organization pursuant to para-  
11 graph (4) for a performance period.

12 “(7) PUBLIC DISCLOSURES.—

13 “(A) IN GENERAL.—For each plan year  
14 beginning on or after January 1, 2028, the Sec-  
15 retary shall make available on a public website  
16 of the Centers for Medicare & Medicaid Serv-  
17 ices and in an easily understandable format, in-  
18 formation regarding the assessments under the  
19 MAO Compliance Program of compliance dur-  
20 ing the performance period with respect to the  
21 plan year by Medicare Advantage organizations,  
22 on the plan level, with requirements applicable  
23 to each compliance category specified in para-  
24 graph (3)(B). Such information shall include  
25 the total compliance score received by each

1 Medicare Advantage organization pursuant to  
2 paragraph (4) for the performance period.

3 “(B) OPPORTUNITY TO REVIEW AND SUB-  
4 MIT CORRECTIONS.—The Secretary shall pro-  
5 vide for an opportunity for a Medicare Advan-  
6 tage organization to review and submit correc-  
7 tions for the information to be made available  
8 under subparagraph (A) with respect to such  
9 organization prior to such information being  
10 made public.”.

11 (b) EXPANDING THE MA STAR RATINGS PROGRAM  
12 TO INCLUDE AN MA PROGRAM COMPLIANCE AND COV-  
13 ERAGE PROTECTION DOMAIN.—

14 (1) DATA COLLECTION.—Section 1852(e)(3) of  
15 the Social Security Act (42 U.S.C. 1395w–22(e)(3))  
16 is amended—

17 (A) in subparagraph (A)(i), in the first  
18 sentence by inserting “, including, for plan  
19 years beginning on or after January 1, 2028,  
20 with respect to measures under the MA Pro-  
21 gram Compliance and Coverage Protection Do-  
22 main described in section 1853(o)(8)” after  
23 “other indices of quality”; and

24 (B) in subparagraph (B)(i), by inserting “,  
25 and other than the types of data authorized

1 under subparagraph (C) of section 1853(o)(8)  
 2 for purposes of the MA Program Compliance  
 3 and Coverage Protection Domain described in  
 4 such section” after “as of November 1, 2003”.

5 (2) ADDITION OF MA PROGRAM COMPLIANCE  
 6 AND COVERAGE PROTECTION DOMAIN TO MA STAR  
 7 RATINGS SYSTEM.—Section 1853(o) of the Social  
 8 Security Act (42 U.S.C. 1395w–23(o)) is amended  
 9 by adding at the end the following new paragraph:  
 10 “(8) MA PROGRAM COMPLIANCE AND COV-  
 11 ERAGE PROTECTION DOMAIN.—

12 “(A) IN GENERAL.—For plan years begin-  
 13 ning on or after January 1, 2028, in addition  
 14 to any other domain under the 5-star rating  
 15 system under paragraph (4)(A) used for deter-  
 16 mining star ratings of Medicare Advantage  
 17 plans, the Secretary shall include under such  
 18 system an MA Program Compliance and Cov-  
 19 erage Protection Domain.

20 “(B) MEASURES.—Such domain shall in-  
 21 clude measures to assess compliance of each  
 22 Medicare Advantage plan with each of the com-  
 23 pliance categories specified in section  
 24 1853(p)(3)(B).

1           “(C) DATA.—For purposes of determining  
 2           star ratings with respect to measures under the  
 3           MA Program Compliance and Coverage Protec-  
 4           tion Domain, in addition to sources of data oth-  
 5           erwise collected under section 1852(e)(3), the  
 6           Secretary may use data collected pursuant to  
 7           audits, complaint tracking systems, appeals  
 8           data, determinations made by independent re-  
 9           view entities, and such other sources as speci-  
 10          fied by the Secretary.

11          “(D) APPLICATION OF WEIGHTING.—In  
 12          applying section 422.166(e) of title 42, Code of  
 13          Federal Regulations, or a successor regulation,  
 14          with respect to the MA Program Compliance  
 15          and Coverage Protection Domain, the Secretary  
 16          shall assign a weight to measures included  
 17          under such domain that is greater than the  
 18          weight assigned to measures included under any  
 19          other domain.”.

20   **SEC. 4. GUARDRAILS ON RETROSPECTIVE CLAWBACKS.**

21          (a) APPLICATION OF PROMPT PAYMENT REQUIRE-  
 22          MENTS TO ALL CLAIMS FOR WHICH AUTHORIZATION WAS  
 23          PROVIDED.—Section 1857(f) of the Social Security Act  
 24          (42 U.S.C. 1395w–27(f)) is amended—

25               (1) in paragraph (1)—

1 (A) in the header, by inserting “FOR ITEMS  
 2 AND SERVICES FURNISHED BY OUT-OF-NET-  
 3 WORK PROVIDERS OF SERVICES AND SUP-  
 4 PLIERS” after “REQUIREMENT”; and

5 (B) by striking “A contract” and inserting  
 6 “Subject to paragraph (2), a contract”;

7 (2) in paragraph (2), by striking “in compliance  
 8 with paragraph (1)” and inserting “in compliance  
 9 with paragraphs (1) and (2)”;

10 (3) by redesignating paragraphs (2) and (3) as  
 11 paragraphs (3) and (4), respectively; and

12 (4) by inserting after paragraph (1) the fol-  
 13 lowing new paragraph:

14 “(2) REQUIREMENT FOR ITEMS AND SERVICES  
 15 FOR WHICH AUTHORIZATION WAS PROVIDED.—

16 “(A) IN GENERAL.—For contract years be-  
 17 ginning on or after January 1, 2028, a contract  
 18 under this part shall require a Medicare Advan-  
 19 tage organization to provide prompt payment  
 20 (consistent with the provisions of sections  
 21 1816(c)(2) and 1842(c)(2)) of qualifying claims  
 22 submitted for authorized items and services (as  
 23 defined in subparagraph (B)) furnished to en-  
 24 rollees under the plan, except that in applying  
 25 the provisions of such sections—

1 “(i) references to ‘not less than 95  
 2 percent of all claims submitted’ shall be  
 3 treated as references to ‘100 percent of all  
 4 claims submitted’; and

5 “(ii) every qualifying claim (as de-  
 6 scribed in subparagraph (C)) submitted for  
 7 an authorized item or service shall be  
 8 deemed to be a clean claim referred to in  
 9 such sections.

10 “(B) AUTHORIZED ITEM OR SERVICE DE-  
 11 FINED.—For purposes of this paragraph, the  
 12 term ‘authorized item or service’ means an item  
 13 or service—

14 “(i) that is furnished by a provider of  
 15 service or supplier to an individual enrolled  
 16 in a Medicare Advantage plan offered by a  
 17 Medicare Advantage organization; and

18 “(ii) for which approval was provided  
 19 by the Medicare Advantage organization  
 20 through a specified authorization (as de-  
 21 fined in section 1852(g)(1)(C)(iii)).

22 “(C) QUALIFYING CLAIM DESCRIBED.—  
 23 For purposes of this paragraph, a claim for an  
 24 authorized item or service is a qualifying claim  
 25 if it includes information sufficient to establish

1           that approval for such item or service was pro-  
 2           vided as described in subparagraph (B)(ii).”.

3           (b) EFFECT OF SPECIFIED AUTHORIZATIONS.—Sec-  
 4           tion 1857(e) of the Social Security Act (42 U.S.C. 1395w-  
 5           27(e)) is amended by adding at the end the following new  
 6           paragraph:

7                   “(7) EFFECT OF SPECIFIED AUTHORIZA-  
 8           TIONS.—Beginning with plan years beginning on or  
 9           after January 1, 2028, a contract under this section  
 10          with an MA organization shall require that, in the  
 11          case that the MA organization approves the fur-  
 12          nishing to an individual enrolled under an MA plan  
 13          offered by such MA organization of an item or serv-  
 14          ice through a specified authorization (as defined in  
 15          section 1852(g)(1)(C)(iii)) made during the receipt  
 16          by the individual of such item or service—

17                   “(A) the MA organization may not, after  
 18                  such approval, deny coverage of such item or  
 19                  service on the basis of lack of medical necessity  
 20                  and may not reopen such a decision for any  
 21                  reason except for good cause (as described in  
 22                  sections 405.986 and 422.616 of title 42, Code  
 23                  of Federal Regulations (or any successor regu-  
 24                  lation)) or if there is reliable evidence of fraud  
 25                  or similar fault (as such terms are defined in

section 405.902 of such title (or any successor regulation)), as determined in accordance with section 422.616 of such title (or any successor regulation); and

“(B) the MA organization may not, after such approval, change the code assigned with respect to the claim for such item or service such that the amount of payment for such claim would be reduced, except for good cause (as described in subparagraph (A)) or if there is reliable evidence of fraud or similar fault (as so described).”.

(c) LIMITATION ON USE OF THIRD-PARTY POST-CLAIM REVIEW ENTITIES.—Section 1852(g) of the Social Security Act (42 U.S.C. 1395w–22(g)) is amended by adding at the end the following new paragraph:

“(6) LIMITATIONS ON USE OF THIRD-PARTY REVIEWS.—

“(A) IN GENERAL.—For contract years beginning on or after January 1, 2028, procedures established by a Medicare Advantage organization for making determinations under paragraph (1), reconsiderations under paragraph (2), or expedited determinations or reconsiderations under paragraph (3), and proce-



dures established for providing for any post-payment review process shall—

“(i) prohibit any third-party entity from conducting a medical necessity review for coverage, payment, or post-payment review for such Medicare Advantage organization unless—

“(I) such review is not with respect to an authorized item or service (as defined in section 1857(f)(2)(B)); and

“(II) such entity is in compliance with the requirements described in subparagraph (B);

“(ii) prohibit the use of any third-party review that is conducted using a routine, automated process for denials in any such review, claim denials, or pattern-based practices of changing a code assigned with respect to a claim for an item or service furnished to individuals enrolled under an MA plan offered by the Medicare Advantage organization to a code that would result in a reduction in the amount of payment for such claim after the item

1 or service has been furnished to the indi-  
2 vidual; and

3 “(iii) prohibit any compensation ar-  
4 rangement with any third-party entity that  
5 provides for payment or other compensa-  
6 tion to such entity based on the number,  
7 percentage, or amount of specified author-  
8 ization requests (as defined in section  
9 1852(g)(1)(C)(iii)) that the entity ap-  
10 proves, denies, or otherwise recommends  
11 for approval or denial.

12 “(B) REQUIREMENTS.—For purposes of  
13 subparagraph (A), the requirements specified in  
14 this subparagraph, with respect to a third-party  
15 entity and a review described in such subpara-  
16 graph, are each of the following:

17 “(i) The entity conducts such review  
18 in accordance with audit protocols and ap-  
19 peal rights, as applicable, that are specified  
20 by the Secretary.

21 “(ii) The entity complies with audit  
22 and public transparency reporting require-  
23 ments specified by the Secretary.”.

1 **SEC. 5. COVERAGE AND MEDICAL NECESSITY CRITERIA**  
 2 **USED BY MEDICARE ADVANTAGE ORGANIZA-**  
 3 **TIONS.**

4 (a) CODIFICATION UNDER THE MEDICARE ADVAN-  
 5 TAGE PROGRAM OF TWO-MIDNIGHT BENCHMARK AND  
 6 PRESUMPTION RULES.—Section 1852(g)(1) of the Social  
 7 Security Act (42 U.S.C. 1395w–22(g)(1)), as amended by  
 8 section 2, is further amended by adding at the end the  
 9 following new subparagraph:

10 “(E) APPLICATION OF TWO-MIDNIGHT  
 11 RULES.—The procedures under subparagraph  
 12 (A) shall provide that, for making determina-  
 13 tions described in such subparagraph with re-  
 14 spect to hospital and critical access hospital ad-  
 15 missions—

16 “(i) in determining whether an indi-  
 17 vidual is an inpatient of a hospital or crit-  
 18 ical access hospital, the Medicare Advan-  
 19 tage organization shall continue to apply  
 20 the provisions of section 412.3(d) of title  
 21 42, Code of Federal Regulations, or any  
 22 successor regulation, in the same manner  
 23 and to the same extent as such provisions  
 24 apply with respect to payment under part  
 25 A; and

1 “(ii) beginning on January 1, 2028,  
 2 in conducting medical review activities,  
 3 with respect to such admissions, the Medi-  
 4 care Advantage organization shall apply  
 5 the two-midnight presumption finalized in  
 6 the rule published by the Secretary in the  
 7 Federal Register on August 19, 2013 (78  
 8 Fed. Reg. 50952), or any successor regula-  
 9 tion, in the same manner and to the same  
 10 extent as such provisions apply with re-  
 11 spect to payment under part A.”.

12 (b) REQUIRING CONSISTENT MEDICAL NECESSITY  
 13 CRITERIA BETWEEN MEDICARE ADVANTAGE AND ORIGI-  
 14 NAL FEE-FOR-SERVICE.—

15 (1) IN GENERAL.—Section 1852(g) of the So-  
 16 cial Security Act (42 U.S.C. 1395w–22(g)), as  
 17 amended by section 4(c), is further amended—

18 (A) in paragraph (2)(B), by striking “A  
 19 reconsideration relating” and inserting “In ac-  
 20 cordance with paragraph (7)(C), a reconsider-  
 21 ation relating”; and

22 (B) by adding at the end the following new  
 23 paragraph:

24 “(7) MEDICAL NECESSITY DETERMINED BASED  
 25 ON FFS REASONABLE AND NECESSARY CRITERIA.—

1           “(A) IN GENERAL.—For purposes of a de-  
2           termination or reconsideration under this sub-  
3           section made on or after January 1, 2028, or  
4           a review made on or after such date by an inde-  
5           pendent, outside entity under paragraph (4),  
6           with respect to coverage for an item or service  
7           furnished to an individual enrolled in an MA  
8           plan offered by a Medicare Advantage organiza-  
9           tion, the Medicare Advantage organization or  
10          independent, outside entity, respectively, shall  
11          not apply criteria for determining the medical  
12          necessity of such item or service that is more  
13          restrictive than the standards and criteria ap-  
14          plied pursuant to section 1862(a)(1) for deter-  
15          mining under parts A and B whether the item  
16          or service is reasonable and necessary.

17          “(B) CERTAIN COVERAGE CRITERIA.—For  
18          purposes of a determination or reconsideration  
19          under this subsection made on or after January  
20          1, 2028, or a review made on or after such date  
21          by an independent, outside entity under para-  
22          graph (4), with respect to coverage of inpatient  
23          hospital services furnished by a rehabilitation  
24          facility (as referred to in section 1886(j)(1)(A))  
25          or long-term care hospital to an individual en-

rolled in an MA plan offered by a Medicare Advantage organization, the Medicare Advantage organization or independent, outside entity, respectively, shall not apply coverage criteria that is more restrictive than the standards and criteria applied under parts A and B, including under—

“(i) paragraphs (a)(3), (a)(4), and (a)(5) of section 412.622 of title 42, Code of Federal Regulations (or any successor to such regulation), with respect to such a rehabilitation facility; and

“(ii) paragraphs (1), (3), and (4) of section 1861(ccc) and clauses (iii) and (iv) of section 1886(m)(6)(A), with respect to a long-term care hospital.

“(C) PERSONNEL.—For purposes of subparagraph (A), a determination, reconsideration, or review regarding the medical necessity of an item or service shall be made only by a physician or other health care professional with appropriate expertise, including education, with respect to such item or service and the related standards and criteria applied pursuant to section 1862(a)(1). For purposes of subparagraph

(B), a determination, reconsideration, or review regarding coverage of inpatient hospital services furnished by a facility or hospital described in such subparagraph shall be made only by a physician or other health care professional with appropriate expertise, including education, with respect to such services and the related standards and criteria applied pursuant to such subparagraph.”.

(2) ENFORCEMENT.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)) is amended—

(A) by redesignating subparagraph (L) as subparagraph (M);

(B) by striking “or” at the end of subparagraph (K);

(C) by inserting after subparagraph (K) the following subparagraph:

“(L) fails to comply with section 1852(g)(7); or”;

(D) in subparagraph (M), as redesignated by subparagraph (A), by striking “subparagraphs (A) through (K)” and inserting “subparagraphs (A) through (L)”; and

1 (E) in the matter following such subpara-  
 2 graph (M), by striking “subparagraphs (A)  
 3 through (L)” and inserting “subparagraphs (A)  
 4 through (M)”.

5 (c) REQUIRING TRANSPARENCY IN COVERAGE CRI-  
 6 TERIA.—Section 1852(a)(2) of the Social Security Act (42  
 7 U.S.C. 1395w–22(a)(2)) is amended by adding at the end  
 8 the following new subparagraph:

9 “(D) TRANSPARENCY IN COVERAGE CRI-  
 10 TERIA.—

11 “(i) REQUIREMENT.—For plan years  
 12 beginning on or after January 1, 2028, in  
 13 order to meet the requirement under para-  
 14 graph (1)(A), in the case of an item or  
 15 service for which there is no national cov-  
 16 erage determination, applicable local cov-  
 17 erage determination, or applicable guid-  
 18 ance for coverage provided by the Sec-  
 19 retary, a Medicare Advantage organization  
 20 offering an MA plan shall—

21 “(I) make a coverage determina-  
 22 tion with respect to such item or serv-  
 23 ice in accordance with publicly avail-  
 24 able evidence-based coverage criteria  
 25 that is published on a public website



1 of the Medicare Advantage organiza-  
 2 tion; and

3 “(II) submit to the Secretary in-  
 4 formation, with respect to every med-  
 5 ical necessity determination made in  
 6 the absence of such national coverage  
 7 determination, applicable local cov-  
 8 erage determination, or applicable  
 9 guidance for coverage, specifying the  
 10 coverage criteria applied under the  
 11 MA plan.

12 “(ii) USE OF INFORMATION.—The  
 13 Secretary shall use the information sub-  
 14 mitted under clause (i)(II) to prioritize  
 15 coverage determinations.”.

16 **SEC. 6. ELIMINATING INEFFICIENCIES IN ADMINISTRATIVE**  
 17 **PROCESSING BY MEDICARE ADVANTAGE OR-**  
 18 **GANIZATIONS.**

19 (a) APPLYING FEE-FOR-SERVICE PROMPT PAYMENT  
 20 REQUIREMENTS TO MA IN-NETWORK SERVICES AS WELL  
 21 AS OUT-OF-NETWORK SERVICES.—Section 1857(f)(1) of  
 22 the Social Security Act (42 U.S.C. 1395w–27(f)(1)), as  
 23 amended by section 4(a), is further amended—

24 (1) in the paragraph heading, by inserting “IN-  
 25 NETWORK AND” before “OUT-OF-NETWORK”; and

1           (2) by striking “if the services or supplies” and  
 2           all that follows through the period at the end and  
 3           inserting “regardless of whether the services or sup-  
 4           plies are furnished under a contract between the or-  
 5           ganization and the provider of services or supplier.  
 6           A claim that is determined to be a clean claim pur-  
 7           suant to the previous sentence or paragraph (2) may  
 8           not subsequently be determined to not be a clean  
 9           claim except under such circumstances and in ac-  
 10          cordance with such criteria as specified by the Sec-  
 11          retary pursuant to notice and comment rule-  
 12          making.”.

13          (b) AUTOMATED REVIEW AND PAYMENT FOR CER-  
 14          TAIN CLAIMS.—Section 1857(f) of the Social Security Act  
 15          (42 U.S.C. 1395w–27(f)), as amended by section 4(a), is  
 16          further amended—

17               (1) by redesignating paragraphs (3) and (4) as  
 18               paragraphs (4) and (5), respectively; and

19               (2) by inserting after paragraph (2) the fol-  
 20               lowing new paragraph:

21               “(3) AUTOMATED REVIEW AND PAYMENT FOR  
 22               CERTAIN CLAIMS.—

23                       “(A) IN GENERAL.—For plan years begin-  
 24                       ning on or after January 1, 2028, a Medicare  
 25                       Advantage organization shall have in place

1 automated payment processes, in accordance  
 2 with standards specified by the Secretary, for  
 3 claims described in subparagraph (B) with re-  
 4 spect to which the provisions of paragraph (1)  
 5 or (2) apply. Such processes shall provide that  
 6 such claims shall be automatically processed  
 7 and paid and shall not be subject to manual  
 8 claim review, except in cases for which there is  
 9 reasonable evidence of fraud.

10 “(B) SPECIFIED CLAIMS.—For purposes of  
 11 subparagraph (A), a claim described in this  
 12 subparagraph is a claim that—

13 “(i) is for an authorized item or serv-  
 14 ice (as defined in paragraph (2)(B)); or

15 “(ii) is for an item or service identi-  
 16 fied on the most recent list published pur-  
 17 suant to section 1852(g)(1)(D)(iii).”.

18 **SEC. 7. MODIFICATION TO NETWORK ADEQUACY STAND-**  
 19 **ARDS FOR CERTAIN POST-ACUTE CARE PRO-**  
 20 **VIDERS.**

21 Section 1852(d)(1) of the Social Security Act (42  
 22 U.S.C. 1395w–22(d)(1)) is amended—

23 (1) in subparagraph (D), by striking “and” at  
 24 the end;

1           (2) in subparagraph (E), by striking the period  
2       at the end and inserting “; and”; and

3           (3) by adding at the end the following new sub-  
4       paragraph:

5           “(F) for plan years beginning on or after  
6       January 1, 2028, the organization provides ade-  
7       quate access to long-term care hospitals and in-  
8       patient rehabilitation facilities, as determined in  
9       accordance with network adequacy standards  
10      specified by the Secretary.”.

○