Advancing High Performance Health

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2025 Issue Brief
Improving Medicare Advantage

Issue

Today, more than half of all Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans.[i] AMGA members care for many of these patients. As a financing model emphasizing preventative care and value, MA aligns with the goals of multispecialty medical groups and integrated systems of care, resulting in improved care at a reduced cost. MA plans incentivize team-based care, resulting in the right care at the right time. Congress should ensure MA reimbursement supports the ability of multispecialty groups and integrated systems of care to deliver high-quality care to beneficiaries. Congress also should review MA policies and direct the Centers for Medicare & Medicaid Services (CMS) to ensure any policies that result in care delays or administrative burden for providers, such as prior authorization, are used judiciously.

With its supplemental benefits and cap on out-of-pocket costs, MA provides an attractive benefits package for beneficiaries and offers providers flexibilities not available under fee-for-service (FFS) Medicare. Our member groups see the value and stability in the MA program, as it provides a consistent set of rules and a financing mechanism that allows them to focus on delivering high-quality care, which fosters care coordination. AMGA and its members are invested in the stability of the MA program, and AMGA supports policies that will allow plans to continue to offer robust benefits to their enrollees. AMGA is concerned recent changes are limiting the attractiveness of MA.

This year, CMS in its Calendar Year (CY) 2026 for MA Capitation Rates and Part C and Part D Payment Policies Announcement finalized changes to the program's risk-adjustment model proposed in the CY 2024 Announcement. At the time, AMGA recommended against changing the Hierarchical Condition Categories (CMS-HCC) model. AMGA believed that removing codes from the HCC model would not address discretionary coding variation, but rather would remove distinct clinical differences from the model. Additionally, removing codes from the HCC model would significantly impact providers' financial stability and enrollee access to services.[ii] CMS will fully implement the 2024 CMS-HCC model, completing the three-year phase-in that began with the CY 2024 Advance Notice. Changes will affect beneficiaries with chronic conditions and lead to lower reimbursements for MA plans. AMGA recommends Congress to carefully consider the impact of these changes.

AMGA recommends Congress examine MA plans' prior authorization practices. Prior authorization serves as an administrative burden and an impediment to timely healthcare delivery. In 2023, 50 million prior authorization requests were made in MA; 3.2 million prior authorization requests were denied and of those appealed, 81.7% were overturned.[iii] Last year, CMS finalized the Interoperability and Prior Authorization Final Rule, which is designed to

improve and streamline the prior authorization process. AMGA supports this goal but emphasizes that the most appropriate way to reduce the administrative burdens associated with prior authorization is to minimize and/or eliminate its use when at all possible, particularly in value-based models of care that have inherently different incentives than FFS models and are designed to promote the most efficient use of resources. In instances where prior authorization is used, we recommend time constraints for the approval process, 24 hours for expedited requests, 48 hours for non-expedited requests, and automatic approval when payors do not respond. We urge policymakers to continue to address prior authorization policies and their impact on patient care.

It is essential that our member multispecialty medical groups and integrated systems of care have access to tools that accurately reflect the needs of the patient populations they serve. MA plans serve a higher proportion of historically underserved beneficiaries and those with social risk factors than FFS Medicare. According to recent data, 40% of all eligible Medicare beneficiaries in rural communities are enrolled in MA. MA plans also have a higher concentration of low- and modest-income patients.[iv] Many MA plans give patients access to supplemental benefits such as vision, dental, and hearing care, addressing the whole of the patient, whereas the traditional FFS Medicare structure does not offer these benefits. Covering these needs is key to addressing longstanding health disparities. Congress must continue to promote policies that reduce significant contributors to poor health outcomes.

AMGA asks Congress to:

- **Consider the impact of cuts to MA that will result in:**
    - **Decreased beneficiary access**
    - **Adverse effects on rural and minority beneficiaries and those with higher social risk factors, as these patient populations enroll in MA plans more than in traditional Medicare**
    - **Decreased care coordination and care management for the chronically ill**
- **Ensure that prior authorization processes are analyzed and then reduced or removed to ensure access to timely quality care.**

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[i] Freed, et. al., Medicare Advantage in 2024: Enrollment Update and Key Trends, KFF, 2024, https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/#:~:text=In%202024%2C%2032.8%20million%20people,receipts%2C%20such%20as%20premiums).

[ii] AMGA Letter on CMS-HCC Risk Adjustment, 2023, amga.org/getmedia/75400037-5d72-48e9-94e0-bedf7fb2dd73/AMGA_CY24_MA_Advance_Notice_Final_3-6-23.pdf

[iii] KFF, Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023, 2025, https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

[iv] Better Medicare Alliance, *State of Medicare Advantage 2024 Report*, BMA, 2024, bettermedicarealliance.org/publication/state-of-medicare-advantage-2024/