



**STRENGTHENING  
MEDICARE ADVANTAGE  
FOR BENEFICIARIES:**

# **RECOMMENDATIONS FOR POLICYMAKERS**

**BETTER MEDICARE**  
ALLIANCE

OCTOBER 2023

# EXECUTIVE SUMMARY

In 2023, more than 31 million Medicare beneficiaries are enrolled in Medicare Advantage, and over 54% of all Medicare beneficiaries are expected to be enrolled by 2030.<sup>1</sup> As the program grows, Better Medicare Alliance (BMA) seeks to partner with community-based organizations, providers, health plans, minority health groups, patient advocates, beneficiaries, and policymakers to develop policy recommendations that enables Medicare Advantage to continue to deliver coordinated, value-based, and affordable care for seniors and people with disabilities.

In this policy report, BMA recommends a series of solutions for policymakers designed to support and strengthen Medicare Advantage for beneficiaries and Medicare more broadly. Foundational to these solutions and work is supporting a stable payment environment to ensure beneficiaries continue to receive the affordable, quality care they depend on and stakeholders across the health care community can continue to innovate in benefit design and care delivery to holistically improve the health care experience. This is especially important as stakeholders implement significant ongoing and new and revised regulations to core components of Medicare Advantage over the next few years.

As policymakers explore opportunities, these policy solutions will continue to build upon the success of Medicare Advantage and maintain and modernize the program to improve the value and care experience for the beneficiaries who choose Medicare Advantage.

## OVERVIEW OF BMA'S RECOMMENDATIONS

### GOAL: ADVANCING HEALTH EQUITY AND REDUCING DISPARITIES

#### Congress could:

- Enable Medicare Advantage plans, through legislation, additional flexibility to target and tailor benefits to address social risk factors based on the health needs of beneficiaries with low socioeconomic status and/or specific subpopulations (e.g., people living with disabilities, who are LGBTQ+, who live in rural communities, and women).

- Update entitlement to Medicare to align with entitlement to disability coverage.

#### CMS could:

- Create alignment of data elements and definitions when developing data collection standards and guidelines for assessment tools and payer software (e.g., electronic health records).
- Assess the impact of new policies focused on reducing disparities and advancing health equity finalized through rulemaking.
- Foster partnerships between health plans, providers, and community-based organizations by providing guidelines and technical assistance (e.g., assisting community-based organizations seeking to partner with health plans to collect and share data).

#### Congress and CMS could:

- Improve integration for dual eligible beneficiaries at both the state and federal level.
- Pursue efforts that enhance and expand retention efforts that support a diverse health care workforce.

### GOAL: ENHANCING SUPPLEMENTAL BENEFIT DATA COLLECTION AND EVALUATION

#### CMS could:

- Provide more detailed information about supplemental benefit offerings available on Plan Finder
- Standardize language and descriptions for supplemental benefits to support beneficiary decision-making.
- Collect standardized data on utilization of supplemental benefits (e.g., by creating new procedure codes).
- Evaluate supplemental benefit use and impact on social, emotional, and physical health outcomes and subsequently highlight any high-value benefits it identifies in public reports with the aim of incentivizing health plans to offer these benefits.

## **GOAL: STRENGTHENING THE VALUE OF IN-HOME HRAs**

### **CMS could:**

- Expand and codify in-home HRA best practices and assess whether health plans act in accordance with the best practices.
- Encourage health plans to incorporate questions related to health equity into all HRAs.

## **GOAL: INCREASING ACCESS TO MENTAL AND BEHAVIORAL HEALTHCARE**

### **Congress could:**

- Support the retention and expansion of the mental and behavioral health workforce.

### **CMS could:**

- Add mental and behavioral health management measures to Star Ratings.
- Facilitate behavioral health provider access to health information technology systems necessary for effective coordination.

### **Congress and CMS could:**

- Require health plans to offer robust mental and behavioral health services with low to no cost sharing.
- Promote the integrations of mental and behavioral health care with primary health care services.

## **GOAL: IMPROVING PROVIDER DIRECTORIES AND ACCURACY OF INFORMATION**

### **Congress could:**

- Require independent audits from health plans and CMS, with results posted publicly.

### **CMS could:**

- Require health plans to standardize their processes for requesting personnel changes from providers.
- Increase accessibility-related information to provider directories.

- Improve provider directory information by establishing shorter deadlines for directory updates.
- Codify additional oversight and requirements for accuracy and timely updates to current Medicare Advantage provider directories, especially for mental and behavioral health.
- Create a national provider directory to streamline reporting and beneficiary access.

## **GOAL: MODERNIZE AND STREAMLINE UTILIZATION MANAGEMENT TO IMPROVE PATIENT ACCESS**

### **Congress could:**

- Enact the Improving Seniors' Timely Access to Care Act, which would require Medicare Advantage plans to establish electronic prior authorization standards.

### **CMS could:**

- Require health plans to provide beneficiaries with clear, detailed, easily accessible information about coverage policies, criteria, and requirements via plan communication and enrollment tools.
- Require health plans to collect and analyze data on electronic prior authorization adoption and integration.

## **GOAL: ESTABLISH MARKETING GUIDANCE THAT SUPPORTS BENEFICIARIES IN MAKING INFORMED CHOICES**

### **Congress could:**

- Enhance oversight of companies engaging in misleading marketing practices.

### **CMS could:**

- Enhance ongoing enforcement of misleading marketing practices.
- Establish a code of conduct and/or best practices for TPMOs with continued oversight from health plans and CMS.
- Prohibit TPMOs from distributing beneficiary contact information.



# INTRODUCTION

Medicare Advantage is a public-private partnership in which over half of seniors and Americans with disabilities eligible for Medicare receive coverage. Unlike Fee-for-Service (FFS) Medicare, where an individual pays separately for hospital visits, provider and outpatient visits, and prescription drugs, Medicare Advantage typically covers all of these services under one monthly health plan and often at a lower cost to the beneficiary. In addition, Medicare Advantage offers additional, supplemental benefits that are not available in FFS Medicare, such as dental, vision, and hearing as well as a range of other non-medical benefits like transportation, nutrition and meals, and wellness programs in an effort to offer comprehensive coverage to beneficiaries.

In 2023, there are over 31 million Medicare beneficiaries enrolled in Medicare Advantage, making up about 51% of all Medicare beneficiaries with Part A and Part B coverage.<sup>2</sup> Medicare Advantage is a proven leader in providing affordable, innovative, and value-based care and 95% of Medicare Advantage beneficiaries report that they are satisfied with their health coverage.<sup>3</sup>

BMA is committed to working alongside community-based organizations, providers, health plans, minority health groups, patient advocates, beneficiaries, and policymakers to advance solutions that will promote coordinated, value-based, and affordable care for all beneficiaries. To further these goals, BMA presents detailed policy recommendations for the Centers for Medicare & Medicaid Services (CMS), Congress, health plans, and other stakeholders to promote reliable, equitable, and high-quality care for seniors and people living with disabilities that choose Medicare Advantage. These policy recommendations will strengthen Medicare Advantage and:

- Advance health equity through better data collection and a diverse and culturally competent workforce
- Enhance supplemental benefit data collection and evaluation
- Strengthen the value of in-home health risk assessments (HRAs)
- Increase access to mental and behavioral health
- Improve provider directory accuracy

- Modernize and streamline utilization management and prior authorization
- Establish marketing guidance that supports beneficiaries in making informed choices

Furthermore, the policy recommendations promote and reflect the current health care system that beneficiaries navigate on a regular basis. In recent years, there has been an ongoing shift to holistically address health and wellbeing, meaning the delivery of care and services is not limited to physical health nor inside a provider's office. Today, beneficiaries receive many services in the community or in connection with their health plan covering social, emotional, and physical health. As such, BMA presents a framing recommendation that the beneficiary experience be measured and evaluated to recognize the transition and modernization of the health care system, including how care is delivered, and how beneficiaries interact with it. For example, current surveys measuring beneficiary experience like the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS) aim to capture the experience within the provider or doctor's office; however, the beneficiary experience extends beyond these places and measures should be updated accordingly to account for how care is delivered today and by the respective stakeholders.





# POLICY RECOMMENDATIONS

## ADVANCE HEALTH EQUITY THROUGH BETTER DATA COLLECTION AND A DIVERSE AND CULTURALLY COMPETENT WORKFORCE

Policymakers are focused on advancing health equity and reducing disparities for Medicare beneficiaries as they age. Notably, in 2022, CMS released an updated framework to advance health equity, with five priority areas guiding CMS's efforts through the next decade. Priorities include:<sup>4</sup>

- Expanding the collection, reporting and analysis of data
- Assessing and addressing inequities in CMS policies
- Building the capacity of the healthcare workforce to reduce disparities
- Advancing the provision of culturally-tailored services
- Increasing all forms of accessibility to health care services and coverage

In 2023, CMS finalized several regulatory policies aimed at reducing health care disparities among Medicare Advantage beneficiaries. First, the Calendar Year (CY) 2024 Rate Announcement noted that CMS will consider publicly releasing reports on Star Ratings measures stratified by Low-Income Subsidy eligibility and disability status; the agency is also developing an unmet health-related social needs question on the HOS.<sup>5</sup> Second, the CY 2024 Medicare Advantage and Part D Final Rule ("Final Rule") replaced the reward factor of the Star Ratings Program with a Health Equity Index and clarified that Medicare Advantage plans with coordinated care plans must provide culturally competent care to all beneficiaries.<sup>6</sup>

Congress is also exploring policy solutions to advance equity for Medicare Advantage beneficiaries. For example, in 2022, Rep. Robin Kelly (D-IL) introduced the Health Equity and Accountability Act of 2022, which would require more detailed reporting of social determinants of health data, direct the U.S. Department of Health and Human Services (HHS) to support health workforce diversity, and increase access to culturally and linguistically appropriate health care.<sup>7</sup>

BMA is supportive of CMS's vision to advance health equity and reduce disparities, such as racial, ethnic, gender, disability status, socioeconomic status, and geographic location. BMA further supports many of the more recent proposals, including the adoption of a Health Equity Index, and has developed a set of policy recommendations for policymakers and health plans to support implementation of this vision for beneficiaries enrolled in Medicare Advantage.

**Enable Medicare Advantage plans, through legislation, additional flexibility to target and tailor benefits to address social risk factors based on the health needs of beneficiaries with low socioeconomic status and/or specific subpopulations** (e.g., people living with disabilities, who are LGBTQ+, who live in rural communities, and women). For example, H.R. 5746, the Addressing Whole Health in Medicare Advantage Act that was recently introduced would expand the criteria for Medicare Advantage beneficiaries eligible for certain supplemental benefits intended to address unmet social needs and is legislation BMA supports. Allowing health plans increased flexibility to tailor benefits to specific beneficiaries and subpopulations would also create additional opportunities for health plans to partner with community-based organizations to further address health disparities and remove barriers to specialized services. For example, health plans offering medically tailored meals as a supplemental benefit could partner with organizations that offer culturally-relevant meal options not only to those with certain chronic conditions as already permitted but to additional beneficiaries who could positively benefit from these types of services

**Create alignment of data elements and definitions when developing data collection standards and guidelines for assessment tools and payer software** (e.g., electronic health records). Alignment of data elements related to health equity could help cultivate accurate and representative data to aid CMS in analyzing and evaluating community needs. As an example, a recent CMS white paper highlights that Medicare and Medicaid use different categories when collecting enrollment data on race and ethnicity; Medicaid includes a category for 'multiracial' that does not exist in Medicare.<sup>8</sup> This misalignment of categories can limit the ability to evaluate the impact on health outcomes and target interventions.

**Update entitlement to Medicare to align with entitlement to disability coverage.** Under the Social Security Disability Insurance program, individuals entitled to disability benefits will become entitled to Medicare coverage after a 24-month waiting period.<sup>9</sup> Congress could align the entitlement date for disability benefits with the Medicare entitlement date, thereby reducing gaps in health care coverage and eliminating barriers to care for people with disabilities.

**Assess the impact of new policies focused on reducing disparities and advancing health equity finalized through rulemaking.** For example, CMS could evaluate the impact of the provisions recently finalized in the CY 2024 Final Rule aimed at reducing disparities in access and outcomes on an ongoing basis. The CY 2024 Final Rule requires that a health plan's quality improvement program must include at least 1 activity aimed at reducing disparities.<sup>10</sup> To build on this directive, CMS should begin measuring the impact of health plans' quality improvement activities on beneficiaries' health outcomes. CMS and other stakeholders should provide guidance on how health outcomes will be measured.

**Improve integration for dual eligible beneficiaries at both the state and federal level.** Opportunities exist to improve the operational, clinical, and financial integration of Medicare and Medicaid to encourage states to pursue more integrated care models for dual eligible beneficiaries, and ultimately, to ensure the delivery of care across the two programs is as seamless and unified as possible for the beneficiary. Policymakers should consider the following initiatives to improve integration for dual eligible beneficiaries:

1. Continue to support states as they work to advance alignment of Medicare and Medicaid and, in working with stakeholders to explore options for states, develop pathways to incorporate features of the sunseting Financial Alignment Initiative (FAI) demonstration into integrated plans.<sup>11</sup>
2. Clearly define partial dual eligible beneficiaries to reduce variability in dual status across states and allow partial duals to enroll in Dual Eligible Special Needs Plans (D-SNPs) under circumstances not already permitted.
3. Lower the 80% limit for dual eligible enrollment in non-SNP plans. In the CY 2024 Final Rule, CMS stated it will no longer renew contracts with non-SNP Medicare Advantage plans if more than 80% of their enrollees are entitled to Medicaid.<sup>12</sup>

4. Enact legislation that builds upon successful delivery models, such as D-SNPs, and improves care coordination for both full- and partial-dual eligible beneficiaries (i.e., the Advancing Integration in Medicare and Medicaid Act and the Supporting States in Integrating Care Act).<sup>13,14</sup>

**Foster partnerships between health plans, providers, and community-based organizations by providing guidelines and technical assistance** (e.g., assisting community-based organizations seeking to partner with health plans to collect and share data). Research shows that community-based organizations, especially those focused on specific diseases or sub-populations, are well-situated to reach beneficiaries and provide culturally competent care.<sup>15,16,17</sup> In partnership with community-based and aging service organizations, HHS and its relevant agencies should:

1. Develop a strategic plan and robust guidelines for health plans to contract and partner with community-based and aging service organizations to deliver care and services.
2. Elevate community-based organizations' data-collecting capabilities and improve data-sharing capabilities between health plans, community-based and aging service organizations, and providers.
3. Enhance and facilitate coordination between CMS, the Administration for Community Living (ACL) and community-based groups.

**Pursue efforts that enhance and expand retention efforts that support a diverse health care workforce.** Diversity and inclusivity among health care staff has shown to improve patient care, result in better health outcomes, and lead to more equitable access to health care services for all communities.<sup>18,19</sup>

BMA welcomes the steps HHS and CMS have taken to ensure a diverse health care workforce, including implementing the Health Care Opportunities program, the Rural Health Network Development Planning program, and more.<sup>20,21</sup>

The Allied Health Workforce Diversity Act (42 U.S.C. 294e(b)), which was included in the Consolidated Appropriations Act (Public Law No. 117-328), will help foster the growth of culturally competent care.<sup>22,23</sup> This Act allows HHS to provide grants to increase diversity in allied health care professions (physical therapy, occupational therapy, respiratory therapy, audiology, and speech-language pathology). These grants will be used to increase the recruitment and retention of students from underrepresented groups.



## POLICYMAKERS COULD TAKE THE FOLLOWING ADDITIONAL ACTIONS:

- 1 Support the initiatives of the Allied Health Workforce Diversity Act by conducting outreach to behavioral and mental health organizations to highlight how the funds can be used to provide in-service training. The agency can play an essential role in encouraging partnerships with community organizations to recruit, train, and retain a diverse health care workforce that could result from this policy change.
- 2 Remain committed to supporting diversity and inclusivity within the health care workforce. Congress could do this by:

**A. Proposing new legislation:** Congress can introduce and pass bipartisan legislation that specifically allocates funds for grants aimed at expanding recruitment of primary care and emergency room providers through the creation of new grants for underrepresented groups. This will further support enhancing quality of care for a diverse patient population.

**B. Collecting data on the impact of the Allied Health Workforce Diversity Act:** The recent congressional changes are an essential step in delivering effective quality care for all patients. While CMS is collecting data on workforce recruitment, CMS should also collect data on the impact of the changes associated with the Allied Health Workforce Diversity Act. The data CMS collects should include race, ethnicity, age, and reported disease states of the patients impacted by this policy change. Highlighting these specific data elements and the patient population treated will help CMS and other stakeholders to identify culturally appropriate quality measures to improve patient outcomes. These data can guide the design of new legislation or support the implementation of the Allied Health Workforce Diversity Act.

## ENHANCE SUPPLEMENTAL BENEFIT DATA COLLECTION AND EVALUATION

Nearly every Medicare Advantage plan offers supplemental benefits not covered in FFS Medicare. Previously, these benefits were limited to “primarily health-related” benefits (e.g., dental, vision, and hearing) and were required to be available to all beneficiaries. Changes in recent years have broadened the scope of supplemental benefit offerings. In 2019, CMS expanded the definition of what constitutes “primarily health-related” supplemental benefits. In addition to medical services, CMS also included other items, such as meal delivery following an inpatient stay. Also in 2019, CMS began allowing health plans to offer disease-tailored benefit designs, including lower cost sharing for certain services or supplemental benefits tailored to certain conditions called Special Supplemental Benefits for the





Chronically Ill (SSBCI), In 2020, CMS allowed health plans to also offer beneficiaries with chronic illness non-primarily health-related benefits, such as food and produce to assist beneficiaries in meeting their nutritional needs.<sup>24</sup>

These changes have allowed for the expansion of supplemental benefit offerings to better meet individual beneficiary needs, address unmet social needs, and provide important clinical care. In 2023, the number of health plans offering at least one of the expansion options of “primarily health-related” benefits increased 35% from the previous year, with the largest increase for in-home support services, followed by caregiver support.<sup>25</sup> These expanded supplemental benefits allow health plans to improve their person-centered care offerings without increasing beneficiary costs. However, there is limited data on the actual utilization and impact of these benefits. A 2023 Government Accountability Office (GAO) report found that a third of health plans offered at least one of the newer supplemental benefits in 2022; however, health plans’ reporting of beneficiary use of supplemental benefits was limited for regulatory and technical reasons.<sup>26</sup> The GAO recommended that CMS clarify its guidance to health plans on whether encounter data should include supplemental benefit utilization, and that CMS should address circumstances where encounter data submission is difficult for health plans.

The recent expansion in supplemental benefits can also make it difficult for beneficiaries and other stakeholders to distinguish and understand the exact benefits being offered by different health plans, leading the Medicare Payment Advisory Commission (MedPAC) to discuss the potential for standardizing supplemental benefits across Medicare Advantage plans in its June 2023 Report to Congress.<sup>27</sup>

Overall, supplemental benefits present many opportunities for Medicare Advantage beneficiaries; however, its recent growth has outpaced the reporting and comparison tools available to health plans, beneficiaries, and other stakeholders.

BMA previously recommended that policymakers and health plans work together to ensure that health plans can:

- Provide coordinated supplemental benefits to ensure beneficiaries are accessing services that will meet their health needs
- Provide structured ancillary benefits, such as vision, dental, hearing, and wellness benefits to promote beneficiary access to high-quality providers

- Tailor benefits for the best health outcomes so beneficiaries receive services that align with care plans
- Provide support and guidance to beneficiaries on accessing and using benefits to increase uptake

The application of these principles would vary depending on the benefit and be designed to ensure access and educate beneficiaries on their available benefits. For example, to the extent not already required, health plans could:

- Assist beneficiaries in accessing supplemental services via customer service centers, web portals, or mobile apps
- Facilitate and track beneficiaries’ use of transportation services to ensure they receive the appropriate transport to their providers
- Ensure that nutrition benefits provide access to healthy and culturally appropriate foods
- Further monitor beneficiary complaints about supplemental benefit providers and provide strong oversight of these service providers
- Provide advocates on behalf of beneficiaries to support use of supplemental benefits available in their health plan
- Offer beneficiaries an appeals process if they report not receiving a service or receiving poor quality service

Additional policy solutions that address some of the challenges and enhance supplemental benefits include:

**Provide more detailed information about supplemental benefit offerings available on the Medicare Plan Finder.** Each year, beneficiaries enrolling in Medicare Advantage must weigh a vast number of factors when deciding which health plan to enroll in, from cost sharing to provider availability, to supplemental benefit offerings. Although health plans use supplemental benefits as an incentive for beneficiary enrollment, there is limited information available on Plan Finder beyond a list of broad service categories. CMS could work in partnership with stakeholders to align standard terminology used to capture social health data (e.g., The Gravity Project) and display additional details on supplemental benefits intended to address those needs in Plan Finder to increase transparency for beneficiaries as they choose a health plan. This information could further be available outside of Plan Finder and included in beneficiary educational materials and initiatives.

**Standardize language and descriptions for supplemental benefits to support beneficiary decision-making.** The variation in plan benefit packages may confuse beneficiaries during their enrollment period. In its June 2023 report, MedPAC noted that supplemental benefits contribute to this variation as health plans choose to cover an increasingly wide range of benefits.<sup>28</sup> As a first step, CMS could consider standardizing the language used to communicate supplemental benefits to beneficiaries to the extent it can given the variability in offerings. For example, CMS could first identify the most commonly offered supplemental benefits, engage stakeholders carrying out this work (e.g., The Gravity Project) to develop common definitions, and offer examples of more nuanced supplemental benefits that may fall under the common definition.

**Collect standardized data on utilization of supplemental benefits** (e.g., by creating new procedure codes). Although health plans are testing new and expanded supplemental benefit flexibilities, there is little data publicly available on the utilization of these benefits. The GAO report notes that current guidance does not specifically outline the process for health plans to submit data for supplemental benefits and highlights that the data submission process is outdated (e.g., not having applicable procedure codes for newer supplemental benefits).<sup>29</sup> CMS could standardize data collection processes for the utilization of supplemental benefits, including the creation of new procedure codes where appropriate to cover expanded supplemental benefit offerings. Information about commonly used supplemental benefits from the revised medical loss ratio data collection process, with data available beginning in 2025, could be used to create new procedure codes as necessary. To determine what data to collect and the best process for data collection, CMS should convene a group of stakeholders (e.g., health plans, providers, community-based organizations) to serve as an advisory board to provide insights and feedback. CMS could further enhance data collection and data sharing requirements through:

1. Medicare Advantage plan reporting: Beginning in plan year 2024, health plans will report supplemental benefit cost and utilization data to CMS. To the extent not already included, CMS could require additional data on the supplemental benefits health plans offer, including detailed information about the types of benefits, enrollment figures, and utilization rates. Data collected by CMS could also be stratified by subpopulation, disease, or health condition.
2. Beneficiary feedback: Establish mechanisms to collect feedback from beneficiaries regarding their experiences with and perceptions of the supplemental benefits they have access to and utilize.

3. Data sharing: Collaborate with relevant federal and state agencies, research organizations, and academic institutions to access and integrate additional data sources, such as health care claims data, to enrich the analysis of supplemental benefit utilization and impact on beneficiaries. Coordination with state Medicaid agencies will support consistent analysis and reporting for beneficiaries enrolled in D-SNPs and limit different conclusions made by states and CMS based on different data specifications established for the same benefit.

**Evaluate supplemental benefit use and impact on social, emotional, and physical health outcomes and subsequently highlight any high-value benefits it identifies in public reports with the aim of incentivizing health plans to offer these benefits.**

Data relating to the impact of supplemental benefits on social, emotional, and physical health outcomes is limited. Additional analysis to identify which benefits have the largest impact on beneficiary health and wellbeing could enable health plans to better target their benefits to address social risk factors. Once a standardized data collection process is established, CMS could:

1. Collaborate with an advisory board of stakeholders engaged in supplemental benefits to evaluate the impacts associated with different supplemental benefits (e.g., flex cards compared to more defined offerings, like groceries) for specific beneficiary populations (e.g., beneficiaries with certain chronic conditions and beneficiaries who are dually eligible).
2. Develop a framework for evaluating the value of different supplemental benefits. This framework would consider factors such as health outcomes, cost-effectiveness, beneficiary satisfaction, and alignment on care objectives. The evaluations could compare the effectiveness and value of various supplemental benefits across health plans and potentially identify high-value benefits that contribute positively to health outcomes and low-value benefits that offer limited support.
3. Publicize the results from impact evaluations and work with the advisory board to identify ways to incentivize health plans to offer the benefits with the most substantial impacts.
4. Categorize supplemental benefits into tiers, indicating their relative value, including beneficiary satisfaction, and depending on impact evaluation. CMS could then create guardrails around the use of supplemental benefits, such as encouraging health plans to focus on offering supplement benefits that fall within higher value tiers or discouraging from the overuse of supplemental benefits deemed lower value. As an



example of encouraging benefits deemed of higher value, CMS could designate (i.e., with a symbol) the health plans that offer higher value supplemental benefits on Plan Finder to incentivize uptake of those benefits and increase awareness for beneficiaries.

As new initiatives take time to implement, policymakers should allow health plans ample time (e.g., at least two years) to ramp up and begin assessing the value of supplemental benefits. Discussions with stakeholders can also be organized to provide a qualitative perspective before and concurrent with quantitative assessments.



## **STRENGTHEN THE VALUE OF IN-HOME HEALTH RISK ASSESSMENTS**

The home has increasingly become a viable site for clinical care, with advancements in technology as the primary driver. In-home health risk assessments (HRAs) have since become an established and integral component of Medicare Advantage, offering health plans a cost-effective way to identify and meet the medical and non-medical needs of beneficiaries in their own homes and communities to better address and improve their health outcomes. In-home HRAs are an important touchpoint to holistically and comprehensively assess beneficiaries in their own environment, and when necessary and possible, connect them to community resources, services, and providers for ongoing care and care coordination. Shifting care into the home then became critical at the onset of COVID-19 and PHE flexibilities suspended and even altogether removed many of the barriers to proving in-home care, especially by allowing hybrid remote and in-person care. In-home HRAs have long been an important tool to understand and address the comprehensive social, emotional, and physical health needs and understanding of beneficiaries.

At the same time, policymakers have expressed concern over the appropriate use of in-home HRAs and the connection to risk adjusted payments in Medicare Advantage despite wide recognition that in-home HRAs are an invaluable tool to fully understand beneficiary health status and support care coordination. For example, CMS requires that SNPs conduct an HRA for beneficiaries as part of the SNP model of care.<sup>30</sup>

### **BMA HAS LONG BEEN SUPPORTIVE OF CODIFYING BEST PRACTICES FOR IN-HOME HRAs, AS WE RECOGNIZE THE ROLE HRAs PLAY IN ASSESSING BENEFICIARY NEEDS AND ADDRESSING URGENT AND DEVELOPING CONCERNS.**

CMS implemented mechanisms to increase oversight through the CY 2022 Medicare Advantage and Part D Final Rule, which requires that SNPs include questions in HRAs that address social drivers of health, beginning in CY 2024.<sup>31</sup> BMA encourages CMS to take additional steps to ensure in-home HRAs are available as a tool for health plans to assess the overall social, emotional, and physical health of beneficiaries, document diagnoses, and identify gaps in care. To strengthen the value of in-home HRAs, policymakers could:

Expand and codify in-home HRA best practices and assess whether health plans act in accordance with the best practices. In the CY 2016 Final Call Letter, CMS provided and encouraged health plans to implement best practices for conducting an in-home



HRA<sup>32</sup> and issued further guidance in 2016, including implementing procedures to make a “best effort” that health plans conduct HRAs annually.<sup>33</sup> Best practices include:

1. All components of the annual wellness visit, including a health risk assessment such as the model health risk assessment developed by the CDC
2. Medication review and reconciliation
3. Scheduling appointments with appropriate providers and making referrals and/or connections for the beneficiary to appropriate community resources
4. Conducting an environmental scan of the beneficiary’s home for safety risks, and need for adaptive equipment
5. A process to verify that needed follow-up care is provided
6. A process to verify that information obtained during the assessment is provided to the appropriate health plan provider(s)
7. Provision to the beneficiary of a summary of the information, including diagnoses, medications, scheduled follow-up appointments, plan for care coordination, and contact information for appropriate community resources
8. Enrollment of assessed beneficiaries into the health plan’s disease management/case management programs, as appropriate

To ensure transparency and accountability for in-home HRA best practices, CMS could mandate annual reporting from health plans that could include the following metrics:

- The organization’s in-home HRAs are compliant with CMS guidelines, including the specified components of the HRA (e.g., contain questions on housing, transport, and food)
- Key metrics, including the number of:
  - a. In-home HRAs conducted
  - b. Medication reviews conducted
  - c. Appointments scheduled as a result of an in-home HRA
  - d. In-home HRA reports delivered to beneficiary’s primary care provider (PCP) or conducted by the beneficiary’s PCP

- e. Beneficiaries receiving an in-home HRA that are enrolled in disease or case management programs

**Encourage health plans to incorporate questions related to health equity into all HRAs.** In 2024, SNPs are required to include specific questions related to health equity, focusing specifically on food, housing, and transportation needs of beneficiaries on their HRAs. Questions related to beneficiary social needs and other drivers of health should be required for all HRAs and not exclusive to SNPs. The information collected could be leveraged by providers, health plans, and community partners to address the whole health of beneficiaries, for example, through accessing and utilizing supplemental benefits and identifying z-codes specific to social drivers of health.

## INCREASE ACCESS TO MENTAL AND BEHAVIORAL HEALTHCARE

Beneficiaries’ access to mental and behavioral health resources varies based on geography. In the CY 2024 Final Rule, CMS finalized several behavioral health-related changes to strengthen network adequacy requirements for health plans and encourage access to telehealth. CMS also increased requirements to ensure availability of behavioral health services for Medicare Advantage beneficiaries, strengthened beneficiary notification requirements for contract terminations of behavioral health providers, and finalized several changes to improve transparency in behavioral health care.<sup>34</sup> The following recommendations will further increase access to mental and behavioral health services:

**Support the retention and expansion of the mental and behavioral health workforce.** A robust supply of mental health providers is critical for integrating mental and behavioral health providers with other health care professionals, such as primary care providers. Policymakers could pursue options such as increasing the number of graduate medical education slots, simplifying the licensure process, including supporting and offering states technical assistance that are interested in cross-state licensing, improving access to culturally responsive mental health care services, and expanding recruitment and retention efforts of rural mental health providers. Congress could particularly focus on increasing the supply of mental and behavioral health professionals in rural areas, where beneficiaries living in rural areas experience similar rates of mental illness compared to urban areas but have far lower access to mental and behavioral health services.<sup>35</sup>

**Add mental and behavioral health management measures to Star Ratings.** Although Star Ratings include measures for other significant conditions (e.g., breast cancer, osteoporosis, diabetes, blood pressure, and bladder control), they do not include measures for mental and behavioral health management. CMS could consider adding appropriate measures that address the health plans' management of beneficiary mental and behavioral health.

**Require health plans to offer robust mental and behavioral health services with low to no cost sharing.** (e.g., requiring coverage of 3 mental health visits in 12 months with no copayment). Health plans can enhance benefits by expanding (1) the continuum of covered behavioral health services, (2) the types of providers eligible for reimbursement, and (3) the settings where health plans can cover mental and behavioral health services. CMS could also consider encouraging health plans to extend coverage with no copayment to primary care providers to encourage beneficiaries to access behavioral health services in a primary care setting.

**Facilitate behavioral health provider access to health information technology systems necessary for effective coordination.** For a number of reasons, electronic health records (EHRs) often cannot accommodate behavioral health services or providers. These systems are costly to implement, and providers need technical assistance to effectively use the systems and incorporate into their workflows. There is an opportunity to promote better coordination of care for individuals with behavioral health needs. For example, CMS could partner with the Office of the National Coordinator (ONC) to create certification standards for behavioral health IT systems. This aligns with a recommendation from the Medicaid and CHIP Payment and Access Commission (MACPAC) in June 2022 and would help behavioral health providers understand what EHR features are desirable or important, particularly in the context of privacy and data sharing.<sup>36</sup> As was done for other health care providers through the HITECH Act of 2009, Congress could authorize funds to improve EHRs for behavioral health care to improve electronic infrastructure.

**Promote the integration of mental and behavioral health care with primary health care services.** Congress and CMS could incentivize health plans to integrate mental and behavioral health care with primary care by encouraging participation in alternative payment models and adopting EHRs. CMS could also incentivize other integration measures by repealing in-person requirements and allowing behavioral health providers to bill independently of other health care providers. Finally, and upon

building a robust workforce, CMS could standardize network access standards between mental and behavioral health providers and primary care providers (e.g., time and distance, wait times, and whether a provider is accepting new patients).

## IMPROVE PROVIDER DIRECTORY ACCURACY

Provider directories are lists of providers maintained by health plans, which are required to maintain provider directories as a public-facing repository of their contracted providers. Beneficiaries rely on these directories to find providers and equip them with the information necessary to make informed decisions on their choice of health plan and provider, based on information such as in-network status, location, language proficiency, and more. However, provider directories can be inaccurate and difficult to use, which may burden beneficiaries, caretakers, and providers.

Provider directory accuracy is a longstanding goal of policymakers and requires the efforts by both the health plan and provider community to ensure accuracy and accountability. For example, health plans rely on providers to update the necessary information quickly and accurately, as the health plan can only update their provider directories as that information becomes available. Similarly, providers frequently navigate many processes to update their information at differing cadences.

In recent years, it has become especially challenging given the complex nature of provider ownership. For example, an increasing number of provider practices are joining larger groups or health systems and individual providers often work in multiple locations. Therefore, establishing a system with improved and accurate provider directories requires cooperation of health plans and providers, and CMS could incentivize these efforts with available tools. Through the use of technology, it is possible to eliminate the need for providers to update their information with every health plan they interact with; rather, providers can utilize a single platform to upload information that all stakeholders have access to.

To increase ease of access, CMS finalized new health equity elements for provider directories (e.g., requirements to list providers' cultural/linguistic capabilities) in the CY 2024 Final Rule. CMS also finalized a provision requiring directories to be searchable by every required data element.<sup>38</sup> CMS is reviewing directories of health plans and piloting several programs to improve reporting and accuracy.

## TO IMPROVE THE UTILITY AND ACCURACY OF PROVIDER DIRECTORIES, POLICYMAKERS COULD EXPLORE VARIOUS SHORT- AND LONG-TERM POLICY OPTIONS, INCLUDING:

- 1 **Require health plans to standardize their processes for requesting personnel changes from providers.** Provider groups have reported that health plans have different processes for reporting personnel changes, which adds unnecessary administrative burden for providers. CMS could require health plans to follow a standardized process for personnel reporting.
- 2 **Increase accessibility-related information included in provider directories.** Beneficiaries need increased access to meaningful provider information to fulfill their unique health care needs. In the CY 2024 Final Rule, CMS required health plans to “include providers’ cultural and linguistic capabilities in provider directories.”<sup>40</sup> CMS could further this initiative by including other accessibility-related information. For example, provider directory information could also include whether a provider has expertise in addressing specific health care needs or chronic illnesses. CMS could also consider including demographic characteristics as a data element for provider directory information within the Star Ratings system.
- 3 **Improve provider directory information by establishing shorter deadlines for directory updates.** Updating changes within a specified timeframe may help to avoid delays or gaps in care for beneficiaries. Currently, health plans are expected to process directory updates within 30 days from the date it is aware of changes.<sup>41</sup> Enhanced accountability on both providers to update the necessary information and health plans to implement the updates may avoid delays or gaps in care for beneficiaries. For example, requirements similar to those established in the No Surprises Act, which requires private and commercial health plans to verify their provider directories every 90 days and make updates within 2 business days could be adopted in Medicare Advantage.<sup>42</sup> Moreover, health plans are responsible for any out-of-network billing for providers mistakenly listed as in-network.<sup>43</sup>
- 4 **Codify additional oversight and requirements for accurate and timely updates to current Medicare Advantage provider directories, especially for mental and behavioral health.** Beneficiaries can review provider directories to decide which health plan to enroll in.

However, the list of providers during the enrollment period may change as providers are permitted to leave a health plan’s network at any time, potentially leaving beneficiaries with a shorter or different list of providers compared to when they enrolled in a health plan. CMS may consider allowing a special enrollment period for beneficiaries whose primary care provider leaves their current health plan network during the year. Alternatively, CMS could consider requiring health plans and providers to remain in contract for the full beneficiary period to minimize disruption in care for the beneficiary.

- 5 **Require independent audits from health plans and CMS, with results posted publicly.** To maintain accurate provider directories, Congress could consider requiring independent audits of health plan directories during the year, with results posted publicly. As accurate provider directories rely on actions of more than one stakeholder, the audits should reflect the shared responsibilities to promote accountability. For example, the audit process could allow for designating the reason for noncompliance or the information that is not accurate and stakeholder responsible for providing the information.
- 6 **Create a national provider directory to streamline reporting and beneficiary access.** CMS could consider creating a national provider directory to aggregate provider listings and improve accuracy, comparability, and beneficiary access. The directory could be fully searchable, include an application program interface for easy access to third-party organizations that support beneficiary decision-making, and offer digital endpoints to support care coordination. Although this may create an administrative burden for stakeholders, including CMS and providers, that may be outweighed by the current burden associated with updating multiple, health plan-maintained directories. The national provider directory should also include:
  1. **The ability to update across public and private directories:** A national provider directory should be designed for interoperability, allowing seamless data exchange with existing provider directory solutions and databases. This includes linking with health insurer and group health plan directories, Medicare, Medicaid, state licensing databases, and health agencies, as well as reputable data sources such as the Council for



Affordable Quality Healthcare (CAQH) and the National Plan and Provider Enumeration System (NPPES).

**2. Resources and incentives to providers:**

Recognizing the administrative burden faced by providers in submitting timely and accurate information to directories, CMS could offer support to encourage provider adoption of a national health directory. To address this, CMS could allocate technical assistance and training. Leveraging best practices and incorporating lessons learned will help create a more efficient and optimized platform, minimizing the burden on providers.

**3. Standardized data elements:** CMS could collaborate with stakeholders to establish a standard set of core data elements and essential fields to populate a national provider directory. The national provider directory should also remain flexible enough to accommodate additional data elements required by specific states or circumstances. For example, it could include optional fields for provider race, ethnicity, gender identity, etc., and should be adaptable to future data requirements.

**4. Include a broad range of health care providers:** Health care providers extend beyond traditional physician practices and hospitals. As such, a national provider directory should encompass ancillary providers such as dental, vision, behavioral health, pharmacies, post-acute care facilities (i.e., skilled nursing and long-term acute care facilities), and social service programs. Including a broader set of health care and social services providers will ensure a national provider directory can address a person's social, emotional, and physical health and wellbeing.

## STREAMLINE AND MODERNIZE UTILIZATION MANAGEMENT AND PRIOR AUTHORIZATION

CMS took steps to increase the efficiency of prior authorization in the CY 2024 Final Rule to reduce health plans' flexibility to use prior authorization and increase limitations on utilization management approaches. Specifically under this rule, CMS limited the use of prior authorization only to confirm the presence of a diagnosis or other medical criteria needed to ensure that the basic benefit is medically





necessary or the supplemental benefit is clinically appropriate.<sup>44</sup> CMS also codified sub-regulatory guidance (section 10.16 of Chapter 4 of the Medicare Managed Care Manual) that states that when a health plan approves a pre-service determination, it cannot later deny coverage or payment based on medical necessity.<sup>45</sup>

Additionally, in December 2022, CMS released an electronic prior authorization proposed rule to improve the efficiency of prior authorization.<sup>46</sup> It is expected to reduce the projected cost of the proposed bipartisan Medicare Advantage bill, the Improving Seniors' Timely Access to Care Act that BMA has endorsed.<sup>47</sup> Congress could pass this and other legislation to improve prior authorization:

**Enact the Improving Seniors' Timely Access to Care Act, which would require health plans to establish electronic prior authorization standards.** These standards include real-time decision-making for routine services, the publication of annual prior authorization information, and measures set by CMS for quality and timeliness of determinations.<sup>48</sup>

BMA welcomes CMS's recent proposed and final rules aimed at streamlining prior authorization protocols within Medicare Advantage, including:

1. Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations and Medicaid Managed Care Plans, State Medicaid Agencies, State CHIP Agencies, CHIP Managed Care Entities, and Issuers of QHPs in the Federally-Facilitated Exchanges proposed rule.<sup>49</sup>
2. Adoption of Standards for Health Care Attachment Transactions and Electronic Signatures, and Modification to Referral Certification and Authorization Standard proposed rule.<sup>50</sup>
3. Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024 final rule.<sup>51</sup>

The above rules align with the bipartisan legislation included in the Improving Seniors' Timely Access to Care Act by implementing an electronic prior authorization process for Medicare Advantage plans, increasing transparency around prior authorization requirements, and expanding beneficiary protections.<sup>52</sup> Despite the progress made, additional changes can further streamline prior authorization in Medicare Advantage. CMS could further build on recently proposed rules by:

1. Incorporating a mechanism for real-time decisions for routinely approved drugs and services. CMS can collaborate with health plans and providers to identify appropriate services eligible for real-time prior authorization decisions.
2. Reducing the deadline to respond to expedited prior authorization requests from 72 hours to 24 hours. This will ensure urgently needed care is not delayed.

CMS could take additional steps to improve the transparency of the prior authorization process for beneficiaries and other stakeholders:

**Require health plans to provide beneficiaries with clear, detailed, easily accessible information about coverage policies, criteria, and requirements via health plan communication and enrollment tools.**

CMS can ensure Medicare beneficiaries have access to clear information on prior authorization before and after their enrollment in Medicare Advantage. CMS could require health plans to create standardized summaries of their prior authorization policies and procedures. These summaries should be written in easily understood language and be readily available on health plan websites and marketing materials. Online tools and communication channels (e.g., helpline, text support, and/or a dedicated email address) should also be available to allow beneficiaries to inquire whether specific procedures and medications require prior authorization.

**Require health plans to collect and analyze data on electronic prior authorization adoption and integration.** To the extent not already required by final or proposed rules, CMS could require health plans to refine data collection processes to ensure it reflects the realities of prior authorization and utilization management practices and processes. Data collected should include information on denials (e.g., denial rates, appeal rates, and decisions following appeal), decision timeframes, use of prior authorization for specific medications and procedures, etc. Once analyzed, data and practices should be made publicly available.

## **ESTABLISH MARKETING GUIDANCE THAT SUPPORTS BENEFICIARIES IN MAKING INFORMED CHOICES**

CMS has responded to the increase in beneficiary complaints about marketing practices conducted by private sector agents, brokers, or third-party marketing organizations (TPMOs). In the CY 2024

Final Rule, CMS finalized restrictions to ensure that beneficiaries are not misled by inaccurate marketing materials. The rule includes provisions to (1) limit the use of the Medicare name, logo, and products or information in health plan marketing materials, (2) increase CMS's authority to review marketing materials, develop marketing standards, and prohibit certain marketing activities, (3) prohibit marketing potential savings to beneficiaries in certain circumstances, and (4) prohibit marketing events from occurring within 12 hours of an educational event. The Final Rule also includes provisions for TPMOs, such as requiring that they disclose the number of health plans they represent in an area.<sup>53</sup>

Congress has also responded to complaints surrounding marketing practices. In 2022, the Senate Finance Committee released a report on misleading marketing practices and potential policy recommendations to address Medicare Advantage marketing.<sup>54</sup>

Additional policies that may further support beneficiaries in making informed health care choices include:

**Enhance ongoing enforcement of misleading marketing practices.** CMS' Medicare Communications and Marketing Guidelines states "plans are responsible for ensuring compliance with applicable federal laws and regulations, including CMS' marketing and communications regulations."<sup>55</sup> According to a 2022 Senate Finance Committee inquiry on deceptive marketing practices in Medicare Advantage, between 2017 to 2022, only one enforcement decision was related to deceptive marketing practices. CMS could increase consequences for health plans and their marketing partners that engage in misleading marketing practices.<sup>56</sup> CMS could consider levying the following enforcement actions, if warranted, on health plans and TPMOs to ensure compliance with its marketing and communication regulations: (1) monetary penalties, (2) suspension of enrollment, (3) immediate suspension of enrollment, (4) immediate suspension of enrollment and marketing, and (5) termination.

**Enhance oversight of companies engaging in misleading marketing practices.** Policymakers could consider increasing funding to organizations that help monitor and report on marketing practices. State Health Insurance Assistance Programs (SHIPs), the Senior Medicare Patrol program (SMP), and Departments of Insurance are independent organizations that provide free, objective information on health plan selection and benefits to all Medicare beneficiaries.<sup>57</sup> The Senate Finance Committee's 2022 inquiry identified these organizations as valuable partners in identifying

local and national companies who are engaging in misleading or deceiving practices.<sup>58</sup>

**Establish a code of conduct and/or best practices for TPMOs with continued oversight from health plans and CMS.** While CMS prohibits various marketing practices for health plans (e.g., reference to statistical data), it does not offer a set of guidelines for TPMOs.<sup>59</sup>

**Prohibit TPMOs from distributing beneficiary contact information.** TPMOs are currently permitted to collect personal beneficiary data and sell this information to other TPMOs. When beneficiaries place a call or click on a web-link related to an advertisement for a Medicare Advantage plan, they are often unaware they are providing consent for their contact information to be shared with other TPMOs for future marketing activities. CMS proposed to prohibit such activity in the CY 2024 Medicare Advantage and Part D Proposed Rule, but the agency did not finalize the policy.<sup>60</sup> However, CMS noted that it may address this provision in a future final rule.





# CONCLUSION

BMA underscores its commitment to partnering with community-based organizations, providers, health plans, minority health groups, patient advocates, beneficiaries, policymakers, and stakeholders to create meaningful program improvements within Medicare Advantage. The policy recommendations presented above will increase care coordination, affordability, and transparency for beneficiaries.

We look forward to continuing to partner with policymakers, including CMS and Congress, as well as other stakeholders to advance the common goal of a Medicare Advantage program valued for delivering high-quality, equitable, and affordable care to beneficiaries. The impact of our joint efforts promotes a coordinated and inclusive health care landscape for both today's Medicare Advantage beneficiaries and the future.



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