Medicare Advantage Lobby Calls For Broad Reforms To Strengthen Program

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CMS and Congress should reform prior authorization and risk adjustment in Medicare Advantage (MA), modernize in-home assessments, and more, the Better Medicare Alliance (BMA) says in a 10-point policy paper the group unveiled last week. BMA says the policy roadmap is a response to CMS Administrator Mehmet Oz's clear call to action.

BMA Vice President of Communications Susan Reilly also tells *Inside Health Policy* that Congress could take a large step toward strengthening the program by passing Rep. Aaron Bean's (R-FL) Apples to Apples Comparison Act (H.R. 4093). The industry-backed bill, which aims to ensure the Medicare Payment Advisory Commission (MedPAC) is making accurate comparisons between FFS and MA, passed the House Ways & Means Committee along party lines in September. Democrats opposed the bill arguing that designed to put MA plans in a better light compared to FFS.

BMA outlines the 10-point policy recommendations in a roadmap released on Sept. 30.
"These reforms would not only strengthen Medicare Advantage by advancing transparency and accountability for taxpayers," BMA says in the report. "They would also make the program work better for seniors -- without raising their healthcare costs or disrupting their coverage. It's a win-win, and we can begin acting immediately."

Prior authorization reform
BMA wants CMS to reduce the agency's mandated decision deadline for expedited prior authorization requests from 72 hours to 24 hours for urgently needed care.

And the organization wants a codified prohibition on AI-only denials without licensed clinician review.

"As health plans increasingly use algorithmic tools to support utilization review workflow, a licensed clinician should remain accountable and at the center of decision-making for making every adverse determination," BMA says.

BMA also wants the federal government to require health plans to increase transparency regarding coverage policies and prior authorization criteria, and for CMS to work with health plans and providers to identify services with consistently high approval rates that are appropriate for faster prior authorization decisions.

BMA supports H.R. 3514, the Improving Seniors' Timely Access to Care Act of 2025. The bill from Reps. Mike Kelly (R-PA) and Suzan DelBene (D-WA) would modernize the MA prior authorization process by requiring MA plans to establish electronic prior authorization programs and meet new beneficiary protection and reporting requirements. The legislation has advanced through both the House Ways & Means Committee and the Energy & Commerce Committee. At an event hosted by Families USA this summer, AARP Government Affairs Director Brendan Rose said he could see lawmakers passing the bill in a year-end package.

Risk adjustment reform

BMA calls for risk adjustment that reflects the full spectrum of beneficiary needs and health status, supports fair and sustainable participation, promotes transparency and stakeholder engagement, tests and phases-in model changes carefully, minimizes administrative burden and focuses on care and ensures integrity and guards against unintended incentives.

Specifically, BMA wants CMS to transition toward an encounter data-only calibrated Medicare Advantage risk model, phased in over a multi-year period. CMS should protect the stability of risk adjustment policy to ensure plans and providers can maintain multi-year value-based care arrangements, BMA says.

BMA wants Congress to require CMS to publish regional actuarial impact analyses alongside any proposed model change.

And BMA wants a move to a multi-year risk adjustment model update cycle, with model updates no more frequently than every three years, except for limited technical corrections, paired with an extended, dedicated stakeholder comment process to run separately from the annual rate notice.

Expanding transparency in supplemental benefits

BMA wants standardized language and descriptions used across MA plans for supplemental benefits to let beneficiaries meaningfully compare offerings during enrollment. And the organization wants plans to offer more support to beneficiaries in understanding, accessing and utilizing available supplemental benefits.

BMA wants CMS' Medicare Plan Finder to include more supplemental benefit information by expanding the definition of primarily health-related supplemental benefits to include healthy food as a standard offering, not only for beneficiaries with chronic illness. And BMA wants the Plan Finder to designate high-value supplemental benefits via a tier rating or symbol.

BMA says CMS should build on the plan year 2024 utilization reporting requirement by collecting and publishing data stratified by subpopulation and condition, and evaluating benefit impact on social, emotional and physical health outcomes.

Modernizing in-home assessments

BMA wants CMS to modernize in-home health risk assessments (in-home HRAs), which the organization describes as "a critical part of the health care experience to foster care coordination, address chronic disease and address the personalized needs of MA beneficiaries."

"Beneficiaries need support navigating and accessing the health care system, and the in-home HRA is well positioned to be that vehicle as more beneficiaries age into Medicare with chronic conditions," BMA says.

BMA says Congress or CMS could promote enhanced follow-up care, for example, by directing plans to contact beneficiaries after every HRA, setting minimum outreach standards, and requiring plans to identify or make an appointment with a primary care provider for every beneficiary.

BMA also wants strengthened program integrity and oversight of HRAs through mandated documentation of follow-up, HRA-focused audits and requiring CMS to develop, collect and publish a defined set of HRA metrics in collaboration with stakeholders.

And BMA wants the federal government to standardize HRA requirements and the clinical model by requiring all in-home HRAs to address CMS' 2016 best practice guidelines, extend standardized questions on food security, housing stability and transportation access to all in-home HRAs and developing best practices governing the frequency and channel of beneficiary outreach for scheduling the in-home HRA itself. BMA is pushing Congress to pass the Medicare Advantage Cost Transparency Act (H.R. 9392), which would require MA encounter data to include information such as the allowed amount for items or services, and the amount of cost-sharing imposed per service.

Ensuring stability and predictability in Star Ratings

“Policymakers should prioritize clinical outcome measures when developing new Star Ratings metrics, and greater stability and predictability should guide the program going forward,” BMA says.

As measure methodology disputes remain unresolved, BMA wants CMS to mitigate unintended disruption to plans and beneficiaries rather than layering additional changes onto an already unsettled rating cycle.

And BMA wants Congress to pass legislation eliminating hard cliffs in the Star Ratings bonus and rebate structure, particularly between 3.5 and 4.0 stars. BMA argues this change “would reward incremental quality gains rather than forcing disproportionate cuts to beneficiary rebates over fractional differences in performance.”

Program integrity

BMA wants annual Risk Adjustment Data Validation (RADV) audits, extended mandatory payment suspension authority to MA and Part D plans, strengthened upfront provider enrollment validation, Fee-For-Service (FFS) enrollment requirements limited to high-risk supplemental benefit vendors, education for Independent Review Entities on fraud patterns in appealed claims and a strengthened Healthcare Fraud Prevention Partnership between CMS and health plans.

BMA says that if CMS expands its preclusion list, there should be “advance outreach, clear communication of the basis for preclusion and adequate lead time for claims processing and beneficiary notification, alongside earlier plan visibility into FFS-suspended or under-investigation providers.”

Protecting beneficiaries from deceptive marketing practices

To eliminate deceptive marketing practices, BMA says CMS should align updates to the maximum Fair Market Value compensation amounts for agents and brokers to the Consumer Price Index or a comparable labor-based index, prohibit third-party marketing organization (TPMO) resale of beneficiary data, establish a formal code of conduct for TPMOs, protect and increase dedicated federal funding for State Health Insurance Assistance Programs and the Senior Medicare Patrol and engage health plans, agents, brokers and beneficiaries in developing performance metrics that incentivize high-value engagement.

Strengthening provider network adequacy

BMA wants CMS to ensure plans and providers are coordinated on implementing the REAL Health Providers Act, which codifies provider director adequacy requirements and was signed into law in February as part of the 2026 Consolidated Appropriations Act (H.R. 7148).

“The Act already addresses BMA's recommendation to shorten timelines for updating directory data,” BMA says. “CMS implementation of the Act should address the development of standardized data elements, clear definitions of accuracy, and recognition when best efforts are made to update and verify data.”

BMA also wants CMS to require plans to standardize their processes for requesting personnel changes from providers, engage a broad range of providers in directory accuracy efforts, work toward a comprehensive, interoperable national provider directory and require periodic independent audits of health plan provider directories, with results posted publicly.

Improving alignment between Medicare Advantage and Veterans Affairs (VA) payments

BMA wants the federal government to establish a data exchange infrastructure between Medicare Advantage plans and the VA.

“Plans need timely, standardized visibility into VA-furnished care, referrals, and cost data for their enrollees -- the same kind of infrastructure BMA is separately recommending for program-wide fraud, waste, and abuse detection,” BMA says.

Supporting value-based care

CMS should ensure plans and providers can design value-based arrangements suited to a specific provider, specialty, condition or region, BMA says.

"A one-size-fits-all model would undercut the flexibility that has made these arrangements effective in the first place," BMA says. -- *Sigi Ris* (sris@iwpnews.com)