Alliance of Specialty Medicine

Sound Policy. Quality Care.

January 26, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically via www.regulations.gov

RE: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program

Dear Administrator Oz,

The Alliance of Specialty Medicine (the "Alliance") represents more than 100,000 specialty physicians across 15 specialty and subspecialty societies who are committed to improving access to specialty medical care by advancing sound health policy. On behalf of the undersigned members, our comments focus on the fundamental policy issues affecting specialists and beneficiaries enrolled in the Medicare Advantage (MA) program. Our feedback on the proposed policies is also intended to inform and respond to the various Requests for Information included in the rule, as the underlying issues are closely intertwined.

Implementation of Certain Provisions of the Inflation Reduction Act of 2022 and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018

Outlier Prescriber Criteria

CMS proposes to codify provisions of the SUPPORT Act related to identifying Part D outlier prescribers of opioids and establish additional requirements for prescribers identified as "persistent" outliers. While we support CMS' goal of improving program oversight and beneficiary safety, ***we caution against policy approaches that rely on blunt statistical thresholds disconnected from clinical context.***

Specialty physicians frequently manage post-operative pain and pain stemming from complex chronic conditions where opioid therapy may be clinically appropriate and highly individualized. Determinations of inappropriate prescribing must be made by peer physicians in the same or similar specialty, after considering patient-specific clinical factors, comorbidities, and treatment history. Policies that fail to account for these realities could discourage appropriate pain management and harm patients with legitimate medical needs.

Experience from clinician-led opioid stewardship initiatives, including specialty-specific peer review models like the Improving Wisely and Practicing Wisely initiatives, demonstrates that meaningful reductions in inappropriate opioid prescribing are best achieved through contextual, physician-to-physician review, rather than reliance on

utilization thresholds alone. These approaches are particularly effective in surgical specialties where episodic prescribing associated with post-operative care may appear as a statistical outlier despite being clinically appropriate.

We appreciate that CMS will continue refining its outlier methodology to ensure alignment with evolving clinical standards, including those developed through the aforementioned initiatives,[1] and Centers for Disease Control and Prevention (CDC) guidelines. ***We urge CMS to operationalize this commitment by ensuring that peer comparison methodologies, thresholds for "persistent" outlier designation, and any downstream plan actions incorporate specialty-specific norms and allow for clinical review before adverse actions are imposed.***

Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies (Operational Changes)

Special Enrollment Period for Provider Terminations

CMS proposes to revise and rename the current Special Enrollment Period (SEP) for Significant Change in Provider Network as the "SEP for Provider Terminations," and to eliminate the requirement for a CMS or plan determination that a provider network change is "significant" before an affected enrollee may use the SEP. CMS also proposes to streamline notification requirements by incorporating SEP-related information into the provider termination notice, including information about the Annual Election Period (AEP) and Medicare Advantage Open Enrollment Period (MA-OEP), the start and end dates of the SEP, and Medigap guaranteed issue rights.

We generally support these proposals and agree that beneficiaries should receive timely, actionable notice when their provider is terminated and clear information about their enrollment options. However, **these changes are insufficient on their own and must be paired with additional requirements to ensure continuity of care for beneficiaries, particularly those who are in active treatment.** Specifically, MA plans should be required to include clear information regarding beneficiaries' options for temporary or transitional in-network access with their current provider, so that enrollees are not forced to abruptly discontinue care or alter treatment plans while navigating enrollment changes.

As we have shared across multiple rulemaking cycles and in recent MA-focused Requests for Information, beneficiaries often do not realize the limitations of their MA plan's provider network until they are faced with a critical need for specialty medical care. This problem is magnified when specialty and subspecialty physicians are terminated, frequently without explanation and sometimes in the middle of a plan year, leaving enrollees without meaningful access to care while they are mid-treatment. While CMS' existing network adequacy standards may deem a network "adequate," Alliance member organizations routinely hear from specialty physicians that beneficiaries report extreme difficulty accessing care.

As an example, in rheumatology – where beneficiaries often require ongoing management of complex, chronic autoimmune conditions – Florida Blue's MA plans terminated approximately two-thirds of rheumatologists for "no cause" in Palm Beach County, Florida, eliminating approximately 32 rheumatologists and leaving only nine in the plan. CMS conducted a network review and shared with concerned stakeholders that, while it recognized the number of rheumatologists eliminated was significant, the plan continued to meet CMS' network adequacy criteria based on plan-reported data. Yet enrollees continued to report extreme difficulty accessing rheumatology care and the medication therapies they had been prescribed, and eliminated practices were unable to secure even temporary in-network status for affected beneficiaries.

As CMS considers finalizing the revised SEP for Provider Terminations, we emphasize that **the core challenge is not the availability of a SEP, but the foundation on which network adequacy determinations are made**. The Alliance and its member organizations have previously raised concerns that CMS' current network adequacy framework relies on a narrow list of primary specialties and quantitative time, distance, and wait-time standards that often fail

[1] Overton, H. N., Hanna, M. N., Bruhn, W. E., Hutfless, S., Bicket, M. C., Makary, M. A., & Opioids After Surgery Workgroup (2018). Opioid-Prescribing Guidelines for Common Surgical Procedures: An Expert Panel Consensus. *Journal of the American College of Surgeons*, *227*(4), 411–418. https://doi.org/10.1016/j.jamcollsurg.2018.07.659

to capture whether beneficiaries can actually obtain timely care from appropriate specialists and subspecialists. Compounding this problem, CMS does not require MA organizations to provide terminated or excluded physicians with a clear explanation of the cause for exclusion or termination, the metrics or criteria used in making that determination, or a transparent process for entering or re-entering the network. As a result, **large-scale specialty terminations occur without transparency, due process, or a pathway for restoring access for beneficiaries who rely on those physicians.**

To ensure that SEP protections function as a meaningful beneficiary safeguard rather than a procedural option without substantive value, ***we urge CMS to act on longstanding Alliance recommendations to improve how network adequacy is assessed, enforced, and made transparent***. Specifically, ***CMS should:***

- ***Require MA organizations to accurately identify physician specialties and subspecialties when calculating network adequacy, using the Healthcare Provider Taxonomy code set developed by the National Uniform Claims Committee, which distinguishes between specialty and subspecialty physicians;***
- ***Expand the list of specialty and subspecialty types included in network adequacy reviews, particularly for specialties managing complex, chronic conditions where continuity of care is essential;***
- ***Require plans to provide terminated or excluded physicians with detailed information regarding the cause for exclusion or termination, including the quality or cost metrics used and clear options for entering or re-entering the network;***
- ***Require plans to maintain accurate, real-time provider directories that include specialty and subspecialty designations, with meaningful enforcement and penalties for noncompliance; and,***
- ***Require greater transparency around provider terminations, including clear information regarding options for temporary or transitional in-network access for enrollees, as noted above.***

Absent improvements to how network adequacy is determined and enforced, beneficiaries who experience provider terminations will continue to face the same barriers that limit the usefulness of the SEP, regardless of how streamlined the SEP process becomes.

Use and Release of Risk Adjustment Data

CMS proposes to broaden the permitted uses and disclosures of MA risk adjustment data to reduce data silos, improve program oversight, and support research and analytics. We agree that, given the rapid growth of the Medicare Advantage program, existing limits on the use and release of risk adjustment data may unnecessarily constrain CMS' ability to evaluate plan behavior and ensure program integrity. However, as CMS expands access to and use of these data, **it is essential that appropriate CMS-mandated oversight activities are distinguished from plan-initiated practices that impose significant administrative burden on physicians and disrupt patient care**.

CMS has previously sought feedback on the nature and extent of medical record documentation requests by MA plans, including ideas to address this burden. As we have repeatedly shared, MA plans continue to misrepresent medical record requests to specialty physician practices as CMS-initiated, mandatory Risk Adjustment Data Validation (RADV) audits. In reality, these requests are frequently plan-initiated and designed to identify additional diagnosis codes, which increase the MA plan's risk score and corresponding Medicare payments.

Preparing for these mischaracterized "audits" is overwhelming for already-burdened physician practices, particularly knowing that the effort is aimed at establishing additional diagnoses to improve plan payments rather than confirming care delivery or quality. Moreover, this burden is unlikely to diminish given CMS' continued focus on risk adjustment oversight, including its appeal of the federal court decision vacating the 2023 RADV final rule. Regardless of the outcome of this litigation, CMS has made clear that risk adjustment audits and oversight are not going away, reinforcing the need to prevent misuse of medical record requests.

As we have previously shared, the scope and volume of plan-initiated medical record requests are substantial, with some plans seeking hundreds of records per physician. These requests are often accompanied by untenable submission deadlines, sometimes just days after receipt. Practices that fail to comply report being threatened with

reduced payment rates or termination from plan networks, effectively forcing compliance at the expense of patient care and practice stability.

To ensure that expanded use and release of risk adjustment data advances program integrity without exacerbating provider burden, ***we urge CMS to require that MA organizations:***

- ***Follow a standardized process for all medical record requests;***
- ***Clearly identify the nature of their medical record request (e.g., RADV, other purpose, etc.) and provide written documentation when requests are mandated as part of CMS-initiated audits;***
- ***Provide reasonable deadlines for medical record submissions, as well as a process for extending the submission deadline for extenuating circumstances;***
- ***Limit the number and volume of medical record requests (e.g., no more than once per year and no more than 20 records per physician);***
- ***Allow practices to submit medical records through a secure web portal, on CD/DVD, or by fax when possible; and***
- ***Reimburse practices for completing medical record requests at a rate no less than is set under State law.***

Absent these guardrails, expanded use and release of risk adjustment data risks perpetuating administrative practices that CMS has repeatedly acknowledged contribute to physician burden, distort plan incentives, and ultimately undermine beneficiary access to care.

Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings)

Removing Measures

CMS proposes to remove several operational, process, and patient experience measures from the Star Ratings program, including:

- *Plan Makes Timely Decisions about Appeals (Part C)* and *Reviewing Appeals Decisions (Part C);*
- *Complaints about the Health/Drug Plan (Part C and Part D);*
- *Medicare Plan Finder (MPF) Price Accuracy (Part D);*
- *Members Choosing to Leave the Plan (Part C and Part D); and*
- *Customer Service and Rating of Health Care Quality (Part C).*

The Alliance strongly opposes the removal of these measures from the Star Ratings program as they directly reflect beneficiary access to care and must continue to meaningfully affect Star Ratings and Quality Bonus Payments, rather than being eliminated or shifted to display-only reporting.

CMS has repeatedly acknowledged that beneficiary complaints, appeals, and related data have been central to identifying problems in the MA program and informing recent policy and enforcement actions. For example, CMS has specifically cited complaints data as evidence of misleading marketing practices, inaccurate provider directories, and failures to ensure access to covered benefits, issues that led the Agency to strengthen marketing rules, third-party marketing organization oversight, and other beneficiary protections.

From the perspective of specialty physicians and the beneficiaries they care for, these measures reflect real and ongoing problems. Appeals and complaint measures, in particular, provide insight into whether plans are meeting their obligations to furnish medically necessary care in a timely manner, especially for beneficiaries with complex or chronic conditions. These measures influence plan behavior the most because they affect plan reputation and payments; **eliminating these measures will mean that complaints, appeals, and access failures no longer factor into plan performance or payment, thus removing any incentive for MA plans to address these issues.**

Streamlining the Methodology, Further Incentivizing Quality Improvement, and Suggestions for New Measures

The Alliance supports CMS' stated goal of simplifying and refocusing the Star Ratings methodology to prioritize measures that meaningfully reflect clinical care, outcomes, and patient experience. Specialty physicians and

beneficiaries continue to report inaccurate provider directories, unexplained network exclusions, non-medical switching of medications, excessive prior authorization requirements, and post-payment review tactics that delay or reduce payment after services are rendered.

To align with CMS' aforementioned goals, ***we urge CMS to consider adopting additional measures to address challenges observed in MA, as previously recommended:***

- ***Establish a star measure awarding points to MA plans that maintain an adequate network of specialty and subspecialty physicians***, to address the issues highlighted in the sections above.
- ***Establish a star measure based on a survey of physicians' experiences with MA plans***, as CMS has previously suggested, which could be developed in collaboration with the Alliance and other professional associations. Questions should focus on the following:
    - Network adequacy, including the accuracy of physician directories and physician termination and reinstatement practices;
    - Payment and reimbursement practices, including the sufficiency of payment rates, the volume of denials and post-payment medical reviews, and other tactics that deny or slow payment after services are rendered;
    - Utilization management, including prior authorization practices, step-therapy requirements, non-medical switching of medications, and other administrative barriers that inappropriately diminish or slow beneficiary access to medically necessary diagnostic and therapeutic services and treatment; and,
    - Other administrative burdens, including the number and type of medical record documentation requests.

***

We appreciate the opportunity to provide feedback on the proposals in this rule. Should you have any questions or would like to meet with the Alliance to discuss these recommendations further, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society for Dermatologic Surgery Association
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society