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January 20, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1834-P
7500 Security Boulevard
Baltimore, MD 21244-1850

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 AAMC[1] welcomes this opportunity to comment on the proposed rule entitled "**Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program**," 90 FR 54894 (November 18, 2025), issued by the Centers for Medicare & Medicaid Services (CMS or the agency).

Enrollment in Medicare Advantage (MA) plans continues to rise year over year, shifting away from Traditional Medicare fee-for-service (FFS) coverage. In 2025, 54 percent of Medicare-eligible beneficiaries were enrolled in an MA plan, up from 19 percent in 2007.[2] This shift in the healthcare payer landscape impacts providers' ability to provide health care services as well as beneficiaries' access to care and overall health. Different payers have varying policies on reimbursement, utilization management, provider networks, and additional benefits offered, which can result in improved or reduced access to care depending on their structure. The increased use of MA plans presents new opportunities to manage beneficiary needs and costs through such policies. AAMC member teaching health systems and hospitals remain committed

[1] The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 162 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 Canadian medical schools accredited by the Committee on Accreditation of Canadian Medical Schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.

[2] KKF, Medicare Advantage in 2025: Enrollment Update and Key Trends. (July 2025)

to supporting efforts to ensure patients maintain access to care, as coverage can directly impact whether beneficiaries have access to care and where they receive such care. As Medicare beneficiaries continue to shift toward MA plans, we hope to continue working in partnership with CMS and other policymakers to ensure access to high quality care.

The following summary reflects the AAMC's key recommendations on CMS' proposals and requests for information (RFIs) regarding MA and Part D plans in the Contract Year (CY) 2027 Medicare Advantage and Part D Policy and Technical Changes proposed rule.

- **Increased Data Access for MA Data:** Finalize proposals to improve access to MA risk adjustment data but continue exploring improvements to MA data transparency.
- **RFI – Competition and Risk Adjustment:** Improve the accuracy of payment in MA to better reflect beneficiary clinical complexity and reduce variability in coding practices.
- **Utilization Management Committees:** Maintain adequate oversight of prior authorization requests.
- **Special Enrollment Periods:** Finalize proposals to streamline eligibility for special enrollment periods due to provider network changes.
- **RFI - Chronic Condition Special Need Plans (C-SNPs):** Prevent enrollment in mismatched or insufficient plans for dually eligible beneficiaries.
- **Marketing and Supplemental Benefits:** Ensure beneficiaries are enrolled in plans best suited to address their healthcare needs.
- **RFI – Wellness and Nutrition:** Evaluate the use of nutrition and wellness related supplemental benefits for impact on beneficiary health outcomes and overall health.
- **Plan Quality Rating System (Star Ratings):** Ensure patients and beneficiaries retain access to critical information on plan performance and compliance with CMS requirements.

INCREASED DATA ACCESS FOR MA DATA

Finalize Proposals to Improve Access to MA Risk Adjustment Data, But Continue Exploring Improvements to MA Data Transparency

Historically, MA risk adjustment data has been less accessible to external stakeholders, including researchers, than Medicare FFS data. Risk adjustment data also includes encounter data. CMS is proposing to remove additional barriers to MA risk adjustment data to better align with the standards for requesting other forms of Medicare data, such as FFS data. This proposal would remove the specific limitations on the uses and disclosure of plan-submitted risk adjustment data but continue protections for plan-submitted payment amounts by only releasing payment information in the aggregate dollar amount. This proposal would also remove the limits on the types of external entities that data may be released to. CMS believes this will provide better access to researchers and other stakeholders for legitimate uses that are in the public's best interest. (P. 54944). Lastly, the agency is proposing to release data on a faster timeline by allowing for the release of data before its final reconciliation.

The AAMC has previously called on CMS to improve access to MA data and ensure data accuracy.[3] **We thank CMS for considering opportunities to improve data transparency in MA to align with FFS and urge the administration to finalize their proposal.** While this is an excellent first step toward improving the use of MA data for research and other purposes that are in the best interest of the public, CMS will also need to ensure accuracy and completeness of MA data and ensure researchers are not priced out of accessing this newly available data. We encourage CMS to ensure this data is offered at low or no cost to researchers so that researchers of all sizes and budgets have the opportunity to access this critical data. Additionally, while we appreciate CMS' concern with providing timely access to this data, if the data is not complete and validated, the risk adjustment calculations may not be accurate, resulting in inaccurate research findings and recommendations for improvements in MA based on inaccurate data. CMS and external stakeholders should consider this if choosing to utilize data released before its final reconciliation.

Lastly, we urge CMS to include standardized costs in the MA encounter data the agency provides, and if needed, explore additional pathways to collect such data if such pathways do not currently exist. It would be beneficial for researchers to understand the types of provider payments utilized by MA plans at the beneficiary level and identify if a plan provides payments to providers through FFS payments, capitated payments, bundled payments, or some other combination or methodology. Such information may be used to assess the accuracy of payment to providers, value of care, and provider satisfaction with the plans. This data should also include payment timelines. Medicare FFS payment timelines have historically been quick and if paid after 30 days includes interest. However, MA payment timelines can often be drawn out due to prior authorization and claims denials creating uncertainty for providers. Understanding these provider payments and timelines will allow stakeholders and researchers to better compare and evaluate MA plans as they relate to Medicare FFS, including evaluating for the allocation of resources and savings in providing care. Such research could lead to improvements to the Medicare program overall.

RFI: Competition and Risk Adjustment

Improve the Accuracy of Payment in MA to Better Reflect Beneficiary Clinical Complexity and Reduce Variability in Coding Practices

Further related to evaluating the allocation of resources and savings in the Medicare program, CMS included an RFI to gain input from stakeholders on replacing or making changes to the existing risk adjustment methodology. (P. 54992). The AAMC appreciates CMS' concerns with the accuracy of the risk adjustment methodology. The Medicare Payment Advisory Committee (MedPAC) identified an estimate of $50 billion in higher payments to MA plans compared to FFS in 2024 due to upcoding.[4] Upcoding is the practice of reporting billing codes in the hopes of

[3] AAMC Comments on CMS' MA Data RFI (May 2024)
[4] MedPAC, March 2024 Report to Congress, Chapter 12: The Medicare Advantage Status Report (March 2024)

receiving higher payment. As the model is currently designed, plans receive higher payments for patients that are coded more intensely, ultimately incentivizing the practice of upcoding. To prevent overpayments in MA and ensure the agency is a good steward of tax-payer dollars to ensure sustainability of the Medicare program for years to come, the agency must evaluate payments for accuracy. **The AAMC urges CMS to explore its options to improve payment accuracy and limit adverse incentives to better reflect the clinical complexity of beneficiaries and reduce variability in coding practices.** Should CMS move forward with new proposals related to risk adjustment in response to this RFI, the agency should do so in a transparent manner. That is, the agency must publicly provide a proper analysis of the impact of any proposed changes to the risk adjustment model and collect sufficient feedback and input from key stakeholders prior to finalizing changes. This approach to changes in risk adjustment will allow for all stakeholders to meaningfully respond and to prepare for any changes.

UTILIZATION MANAGEMENT COMMITTEES

Maintain Adequate Oversight of Prior Authorization Requests

CMS is proposing to remove a number of Utilization Management Committee requirements, including the requirement to report metrics for prior authorization for each item or service rather than the aggregate for all items and services. (P. 54988). The AAMC urges CMS to maintain the existing reporting metrics for each item or service. Utilization Management Committees are responsible for conducting annual reviews of related policies and processes, including the use of prior authorization. These reviews are used to ensure plans are following Medicare coverage requirements. The AAMC has encouraged CMS to continue strengthening the work and commitment the agency has made to better understand the use of prior authorization in MA.[5] The agency's newest proposal would unravel these efforts and set the agency back in terms of oversight and accountability of the plans. The current regulations provide a baseline understanding of how plans are using prior authorization, allowing the agency to gauge if such requests are helping or hindering patient care and access. **Additionally, we recommend that when prior authorization requests are denied, CMS should require reporting by plans to obtain information on the timeliness of determinations and reasons for denials, claims and payment requests denied after a service has been provided, beneficiary out-of-pocket spending, and disenrollment patterns stemming from these denials.** These data points will allow policymakers and regulators to adequately oversee the program and create potential reforms as needed.

Further, CMS requests comment on whether the agency should revise Utilization Management Committee composition requirements, including representation of various clinical specialties. (P. 54989). **The AAMC urges CMS to maintain adequate oversight of prior authorization use and finalize policies that ensure plans are using clinical understanding, literature, and appropriate expertise to make decisions on prior authorization requests.** If a Utilization Management Committee does not have the specific expertise to properly decide on a prior

[5] AAMC Comments on MA Data RFI (May 2024)

authorization request, it should be required to seek outside assistance from an entity or entities with expertise in the subject.[6] This will ensure that prior authorization requests are not denied strictly because of the committee's lack of clinical knowledge or expertise. Plans should ensure a robust mix of clinical specialists are represented in their Utilization Management Committees to maximize the committees' understanding and knowledge.

SPECIAL ENROLLMENT PERIODS

Finalize Proposals to Streamline Eligibility for Special Enrollment Periods due to Provider Network Changes

CMS is proposing to change the eligibility criteria to qualify for a Special Enrollment Period (SEP), due to a significant change in the provider network, to no longer require a determination from CMS in the event of a provider network change. Instead, beneficiaries will be able to contact CMS directly and request an SEP without the specific determination from CMS first. CMS plans to reduce the number of notifications to beneficiaries into one by including SEP information in the provider termination notice issued to impacted beneficiaries. Beneficiaries that qualify for a SEP include those who are "assigned to, currently receiving care from, or [who] has received care within the past 3 months from a provider or facility being terminated from the provider network." Beneficiaries will become eligible for the SEP in the month in which they are notified of the termination and for up to two months following. (P. 54941).

The AAMC supports CMS' efforts to ensure beneficiaries may continue to access care despite provider terminations from a plan's network. **We urge the agency to finalize these proposals to enable beneficiaries to decide whether to seek care from another provider or switch plans to maintain access to their current provider.** This is especially needed for specialty and sub-specialty care where access may be limited to their current provider, making it impossible to continue to access this care in network following a provider termination. Narrow networks can limit beneficiaries' access to providers and could be further exacerbated by provider contract terminations, necessitating the need for beneficiaries to have flexibility in the event of such a termination. Teaching hospitals and their associated faculty physicians are often the only providers able to provide specialized and sub-specialized care. Ensuring that MA beneficiaries have access to teaching hospitals and their associated providers, even in the event of provider contract terminations, will safeguard beneficiaries' access to a greater number and type of providers to meet their health care needs.

RFI: CHRONIC CONDITION SPECIAL NEED PLANS

Prevent Enrollment in Mismatched or Insufficient Plans for Dually Eligible Beneficiaries

In an RFI, the agency shares its concerns with recent significant enrollment growth in Chronic Condition Special Needs Plans (C-SNPs) and Institutional Special Needs Plans (I-SNPs). CMS is

[6] AAMC Comments on the CY 2024 MA and Part D Policy and Technical Changes Proposed Rule (February 2023)

concerned that dually eligible individuals may be enrolling in these plans rather than Dual Eligible Special Needs Plans (D-SNPs) that offer integrated Medicare-Medicaid benefits. These plans are specifically designed to provide targeted care and limit enrollment to special needs individuals to ensure their health needs are met. To address these concerns, CMS is seeking input from stakeholders on how to ensure dually eligible beneficiaries are enrolled in integrated plans and how to mitigate the agency's concerns that C-SNPs and I-SNPs may be undermining CMS' efforts to integrate Medicare and Medicaid services. (P. 54978).

In the CY 2025 MA and Part D Policy and Technical Changes final rule, CMS finalized policies to increase the number of beneficiaries receiving integrated Medicare/Medicaid services from the same plan. The agency also expanded and finalized its policies on look-alike plans by proposing to lower the D-SNP look-alike threshold. Any plan that has the relevant percentage of dual eligibles enrolled but that is not a D-SNP would lose its MA contract and not be able to re-contract with CMS until it met the percentage threshold or become a D-SNP plan.[7] CMS should continue to pursue similar policies for other types or SNPs to ensure beneficiaries are able to select plans that best meet their own individual health needs, including in the case of C-SNPs and I-SNPs. The AAMC previously supported CMS' efforts to limit D-SNP look alike plans and emphasized the need to continue to monitor and address potential loopholes in prohibiting D-SNP look-alike plans.[8]

With that said, we urge CMS to explore similar policies for I-SNP and C-SNP plans as those used to lower the number of and enrollment in D-SNP look-alike plans for beneficiaries that are dually eligible. However, in this case, CMS will need to take precautions to ensure that limitations on C-SNP and I-SNP plans do not prevent beneficiaries who require these kinds of specialized care from enrolling. Further, as the number of individuals in these types of plans continues to increase, so does the need for accurate data and oversight, which will allow for a greater understanding of how these plans address beneficiary needs and improve health outcomes for some of MA's most vulnerable enrollees. We urge CMS to explore additional policies for data transparency related to D-SNP, I-SNPs, and C-SNPs to ensure and maintain sufficient access for this population of MA enrollees and their specific needs.

MARKETING AND SUPPLEMENTAL BENEFITS

Ensure Beneficiaries Are Enrolled in Plans Best Suited to Address Their Healthcare Needs

Within this year's proposed rule, CMS requested input on how the agency can improve oversight of plans' marketing practices, including the use of third-party marketing organizations, agents, and brokers. (P. 54950). We support CMS' interest in improving oversight of plan marketing to protect beneficiaries from misleading or predatory marketing and advertising practices. The AAMC has previously expressed our concerns with unregulated marketing practices that may mislead beneficiaries towards plans that do not best meet their health care needs due to narrow

[7] 89 FR 30448
[8] AAMC Comments on the CY 2025 MA and Part D Policy and Technical Changes Proposed Rule (January 2024)

provider networks or increased barriers to care due to overly burdensome utilization management tools.[9] This mismatch can negatively impact beneficiary access to care and worsen health outcomes. Beneficiaries may ultimately become priced out of alternative Medicare plans if they are misled at the time of their original Medicare enrollment. This is especially true for Medicare FFS plans due to the cost of Medigap coverage, even if an FFS plan may better suit their healthcare needs. This is due to the expiration of limitations on the prohibition of varying premiums based on pre-existing medical conditions for Medigap plans. After a one-time, six-month Medigap open enrollment period, that begins the first month of a beneficiaries' Medicare Part B coverage, or within the first year of enrolling and disenrolling in an MA plan, these prohibitions expire. This means that Medigap plans may utilize medical under-writing, ultimately raising premiums or excluding beneficiaries from certain services.[10]

Further, a 2023 report from the Senate Finance Committee highlights the themes of beneficiary complaints in response to open enrollment advertisements and marketing.[11] These themes may serve as a starting point for CMS to explore improvements to marketing oversight to meet the needs of the American people. As the number of MA plans offered increases and more Medicare eligible beneficiaries choose to enroll in MA, it is imperative beneficiaries receive accurate information on the plans available. **We urge CMS to continue improving the oversight of MA marketing and advertising practices to ensure beneficiaries are matched to a plan best equipped to meet their health needs.**

CMS further proposes to remove the requirement for plans to issue mid-year notices of unused supplemental benefits. (P. 54987). The AAMC has previously supported notifying beneficiaries of unused supplemental benefits.[12] Beneficiaries may make enrollment decisions based on the supplemental benefits advertised to them during the annual election period but may be missing out by not utilizing them during the plan year.[13] This could be attributed to lack of awareness on how to utilize these benefits or that a beneficiary is entitled to them. However, MA plans have been accused of using supplemental benefits as a misleading marketing practice.[14] The inclusion of mid-year notices to beneficiaries on unused supplemental benefits may help to inform beneficiaries on how to use them as well as mitigate concerns that supplemental benefits may be used by MA plans as a misleading marketing practice.

RFI: WELLNESS AND NUTRITION

Evaluate the Use of Nutrition and Wellness Related Supplemental Benefits for Impact on Beneficiary Health Outcomes and Overall Health

[9] AAMC Comments on the CY 2026 MA and Part D Policy and Technical Changes Proposed Rule (January 2025)
[10] KFF, Key Facts About Medigap Enrollment and Premiums for Medicare Beneficiaries (October 2024)
[11] Majority Staff of the U.S. Senate Committee on Finance, Deceptive Marketing Practices Flourish in Medicare Advantage (November 2023)
[12] AAMC Comments on the CY 2025 MA and Part D Policy and Technical Changes Proposed Rule (January 2, 2024)
[13] MedPAC, June 2025 Report to Congress, Chapter 2v (June 2025)
[14] KFF, How Health Insurers and Brokers Are Marketing Medicare (September 2023)

CMS included in this year's proposed rule a request for information for input on well-being and nutrition policy changes for consideration in future years. (P. 54994). Nutrition plays a central role in preventing, managing, and treating many of the chronic diseases that continue to drive morbidity, mortality, and health care costs in the United States. The AAMC recognizes this and continues to engage in strategic efforts to improve nutrition education across the medical education continuum.[15] We encourage medical schools and academic health systems to identify areas of opportunity to further embed nutrition learning into their curriculum, ensuring physicians are prepared to address the role of nutrition in patient care. Further, the AAMC remains committed to working with CMS to improve the overall health and well-being of patients across the US through these initiatives.

MA plans utilize a wide range of supplemental benefits in various formats to meet beneficiaries' health needs that go beyond traditional Medicare coverage. As an example, related to this RFI, some MA plans offer debit cards for healthy foods or home-delivered meals. However, these may be restricted to plans for chronically ill beneficiaries who qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI). In 2024, CMS finalized a requirement for MA plans offering these kinds of benefits to demonstrate, with support from research, that SSBCI items and services meet the legal threshold of having a reasonable expectation of improving the health or overall function of chronically ill enrollees.[16] While this requirement may add additional burden onto plans offering nutrition supplemental benefits, this submitted data provides CMS with a starting point to evaluate different nutrition and well-being related interventions currently used by MA plans as supplemental benefits. The agency may be able to analyze and identify interventions that should be tested for wider use within the MA population. Should these interventions improve health outcomes and overall health, the agency may consider standardizing such supplemental benefits for wider use in the future. However, the AAMC emphasizes that investments into these types of supplemental benefits to improve health outcomes must be rooted in evidence-based findings to support their use and ensure the agency can achieve its intended goals.

PLAN QUALITY RATING SYSTEM (STAR RATINGS)

Ensure Patients and Beneficiaries Retain Access to Critical Information on Plan Performance and Compliance with CMS Requirements

CMS proposes to remove seven existing Star Ratings measures focused on operational and administrative performance and two measures focused on patient experience of care. (P. 54965) Notably, measures proposed for removal include "Plan Makes Timely Decisions about Appeals," "Reviewing Appeals Decisions," "Complaints about the Health/Drug Plan," and "Members Choosing to Leave the Plan," all measures that provide critical information to patients and consumers when choosing a health plan. CMS notes that the measures proposed for removal

[15] AAMC, Strengthening Nutrition Education Across the Medical Education Continuum
[16] 89 FR 30448

"have been invaluable to CMS's efforts to monitor and improve plan performance and compliance in critical operational areas," and suggesting the measures could be better used for the agency's monitoring and compliance efforts rather than as quality measures for the Star Ratings program. (P. 54965) **The AAMC encourages CMS to retain these measures in a transparent manner for purposes of monitoring and improving plan performance and compliance with program requirements to ensure patients and beneficiaries retain access to critical information.**

CONCLUSION

Thank you for the opportunity to comment on this proposed rule. We remain committed to supporting improvements to transparency and access in MA plans as more Medicare eligible beneficiaries enroll in MA. The AAMC's concern for these issues has increased as the program continues to grow, requiring more data transparency, accurate payment, adequate provider networks, and proper oversight to maintain beneficiary access to care. We would be happy to work with CMS on any of the issues discussed or other topics that involve the academic community. If you have questions regarding our comments, please feel free to contact Katie Gaynor (kgaynor@aamc.org) or Phoebe Ramsey (pramsey@aamc.org).

Sincerely,

Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
Chief Health Care Officer

cc: David Skorton, M.D., AAMC President and Chief Executive Officer