



Sound Policy. Quality Care.

March 1, 2024

Meena Seshamani, MD, PhD
Director, Center for Medicare
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue
Washington, DC 20201
Submitted electronically via Regulations.gov

RE: Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Dear Dr. Seshamani,

The Alliance of Specialty Medicine (the “Alliance”) represents more than 100,000 specialty physicians across 16 specialty and subspecialty societies. The Alliance is deeply committed to improving access to specialty medical care by advancing sound health policy. On behalf of the undersigned members, we write in response to the 2025 Advance Notice.

Quality Rating System: Potential New Measure Concepts

We appreciate CMS’ solicitation of comments on new measure concepts to inform future changes to the Star Ratings program. Our specialties are concerned that, with Medicare Advantage enrollment having surpassed 50% of total Medicare enrollment, there is an even greater need to hold plans accountable for additional aspects of quality and access to care. Below we outline potential new measure concepts that CMS should consider for future years.

Prior Authorizations

We appreciate CMS’ efforts to address challenges that practices and patients face with prior authorizations, particularly those policies finalized in the *2024 Medicare Advantage and Part D Policy and Technical Changes* and the *Advancing Interoperability and Improving Prior Authorizations* final rule. As a complement to these efforts, we support a new quality measure – *Level I Denials Upheld Rate Measure* – recently recommended by the Partnership for Quality Measurement (PQM) Pre-Rulemaking Measure Review (PRMR) Clinician Recommendation Group for adoption in the Star Ratings program. The Alliance agrees with the group’s rationale that the measure “*could reduce frustration of obtaining unnecessary prior authorizations with Medicare Advantage,*” and **urges CMS to adopt this measure through rulemaking for CY 2026 and beyond.**

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American Association of Neurological Surgeons • American College of Mohs Surgery • American College of Osteopathic Surgeons
American Gastroenterological Association • American Society for Dermatologic Surgery Association
American Society of Cataract & Refractive Surgery • American Society of Echocardiography • American Society of Plastic Surgeons
American Society of Retina Specialists • American Urological Association • Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons • National Association of Spine Specialists • Society of Interventional Radiology

Physician/Plan Interactions

In the CY 2019 Medicare Advantage and Part D Policy and Technical Changes Proposed Rule, CMS solicited and received feedback about conducting a survey of physicians about their interactions with plans on behalf of beneficiaries. In the 2020 Advance Notice, CMS said that *“the vast majority of commenters recommended against a mandatory survey,”* citing concerns such as burden, potential for skewed results, and that most plan interactions are with centralized staff. We contend that the vast majority of commenters were Medicare Advantage plans – not physicians – and that physician organizations likely were unaware of the proposal.

The Alliance strongly supports a Star Ratings measure based on a survey of physicians’ experiences (which would include the physician’s clinical and administrative staff) with Medicare Advantage plans, and asks the agency to adopt this measure for CY 2026 and beyond.

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;
- Contracting, including the process used to negotiate plans payments;
- 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 referral requirements and the number and type of medical record documentation requests, including those required as part of CMS’ Risk Adjustment Data Validation and those required by the plan to establish additional diagnosis for purposes of increasing beneficiary risk scores.

We urge CMS to propose this potential new measure concept in the CY 2026 rulemaking cycle, and to ensure the physician community is made aware of the proposal and the opportunity to comment. At a minimum, communication vehicles should include the Medicare Learning Network (MLN) Connects Newsletter, regular communications to physician’s by the Medicare Administrative Contractors (MACs), as part of a “First Friday Clinician Outreach Meeting,” and by direct outreach to the leadership of national and state medical and specialty societies.

Network Adequacy

The adequacy of MA plan networks and the accuracy of provider directories continue to be problematic for providers and enrollees. Some specialists are facing increased rates of “no cause” terminations, while in other cases, specialties and subspecialties are not counted in networks, at all. To mitigate these issues, we urge CMS to:

- **Update the “specialty types” that plans must ensure meet CMS’ time/distance standards so that all specialties and subspecialties are considered.** Currently, plans are only held accountable for 27 provider specialty types. By not including the full range of specialists and subspecialists, it is impossible for a plan’s network to be truly adequate.
- **Revise the time/distance standards that better reflect beneficiary access to care needs.** CMS’ current time/distance standards are woefully inadequate for most speciality types,

particularly for those specialties that face critical workforce shortages or that treat diseases that are currently at epidemic levels, or increasingly common in the Medicare population.

- **Add appointment wait time standards for all specialties.** Wait time standards have been adopted for primary care and behavioral health, yet there are increasing reports of patients being unable to access specialty medical care in a timely fashion.
- **Require transparency in value metrics used for network management.** Medicare Advantage plans routinely evaluate the providers in their network based on quality and cost metrics. Based on these evaluations, physicians may be “tiered” relative to other physicians, and in some cases, terminated from the plan’s network. Plans should be required to publicize the value metrics they are using for network management so that physicians know the standard by which they are being evaluated. In addition, physicians should receive detailed feedback about the plan’s evaluation of their quality and cost, along with an opportunity to appeal any decision and rejoin the plan’s network.

We appreciate the opportunity to comment on these important issues and welcome the opportunity to meet with you to discuss them in more detail. Should you have any questions or wish to schedule a meeting, please contact us at info@specialtydocs.org.

Sincerely,

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