January 23, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4212-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via https://www.regulations.gov

Dear Administrator Oz,

The American Academy of Dermatology Association (AADA) appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) in response to the calendar year (CY) 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Cost Benefit Program, and Medicare Cost Plan Program. The AADA represents more than 17,500 dermatologists nationwide who are committed to excellence in the medical and surgical treatment of skin disease; advocating for high standards in clinical practice, education, and research in dermatology and dermatopathology; and driving continuous improvement in patient care and outcomes while reducing the burden of disease.

The AADA appreciates CMS' efforts to evaluate and update Medicare Advantage (MA), the Medicare Prescription Drug Cost Benefit Program (Part D), and the Medicare Cost Plan Program. Areas of particular importance to the AADA are the composition of MA Utilization Management (UM) Committees, UM practices, passive enrollment, Star Ratings appeal measures, provider termination notifications, and network adequacy. The AADA offers the following comments on these initiatives.

Reducing Administrative Burdens Associated with Utilization Management Committee Requirements

We appreciate CMS' forward-thinking request for recommendations regarding MA Utilization Management (UM) Committee composition requirements. UM Committees play a crucial role in shaping policies and procedures that impact patient care and can impose unnecessary regulatory burdens on accessing care. One in

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four Americans are impacted by skin diseases, representing a substantial number of Americans negatively impacted by current regulatory burdens on dermatologic care.[1]

Policies developed by UM Committees, particularly poorly designed prior authorization requirements, significantly burden patients' ability to access dermatologic care. Dermatologists have reported significant regulatory burdens as the result of prior authorization requirements. For instance, without prior authorization requirements, dermatologists could see up to five to eight extra patients per day. As a result of prior authorization, 27% of patients experience a delay or abandon treatment, 36% are forced to use less appropriate treatment, and 37% are pushed into step therapy – another regulatory burden restricting and frequently delaying the most appropriate patient care.[2]

Furthermore, dermatologists' active involvement in efforts to reduce burdensome regulations makes them well-suited to serve on UM Committees and drive policy improvements to alleviate regulatory burdens to timely, high-quality healthcare. **In alignment with Executive Order 14192's goal of reducing regulatory burdens on Americans, we recommend including dermatologists as required UM Committee members to help eliminate unnecessary and harmful barriers to dermatologic care.**

Rescinding Health Equity Analyses: Annual Health Equity Analysis of Utilization Management Policies and Procedures

CMS' proposal to eliminate the annual health equity analysis of prior authorization would reduce transparency that currently allows stakeholders to evaluate how utilization management practices, specifically prior authorization, impact access to care. Poorly designed prior authorization programs routinely drive up direct and indirect costs for patients through delays in care and medical decision making, increase patient stress and can result in negative care outcomes, and place substantial administrative burdens on physicians. The existing analysis serves as a quality check to help maximize the value of the MA program and promote improved health outcomes for all beneficiaries, aligning with CMS' goals for quality and efficiency.

We urge CMS to retain this annual analysis and refine it by requiring the analysis to report metrics at the individual item or service level rather than in aggregate. This added granularity would strengthen transparency and give stakeholders a clearer understanding of how prior authorization policies influence access to care across specific services and populations, as well as the cost/benefit of prior authorization by service.

[1] The burden of skin disease in the United States. Lim, Henry W. et al. Journal of the American Academy of Dermatology, Volume 76, Issue 5, 958 - 972.e2.
[2] American Academy of Dermatology. Prior Authorization's Impact on Dermatologists. 2020. Available at https://www.aad.org/member/practice/drugs/prior-authorization/impact-dermatologists. Accessed 12/10/25.

Improvements for Special Needs Plans: Passive Enrollment by CMS (§ 422.60)

We applaud the intent of the CMS' proposal to expand the period for continuity of care for all incoming enrollees to Dual Eligible Special Needs Plans (D-SNPs) operated by MA organizations from 90 days to 120 days. By extending the period to 120 days, CMS reduces the risk of disrupting patient–provider relationships and helps ensure that enrollees continue to receive essential medications and treatments during their plan transition. We commend CMS for its commitment to ensuring enrollees have uninterrupted access to necessary care during plan transitions and initial enrollment. CMS' proposal to expand the period for continuity of care would be further strengthened through accompanying actions that ensure all plan networks are robust and offer comprehensive access to dermatologic services, as discussed in greater detail in the Provider Network Participation recommendations below.

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

The Academy appreciates CMS' effort to evaluate and update MA and Part D programs and the efforts to review and update Star Ratings measures. At the same time, we highlight concerns with CMS' proposal to retire four measures regarding plans' reviews of appeals given improving performance over time. The measures: Plan Makes Timely Decisions about Appeals (Part C), Reviewing Appeals Decisions (Part C), Complaints about the Health/Drug Plan (Part C and D), and Members Choosing to Leave the Plan (Part C and D), have successfully driven quality improvement.

The Plan Makes Timely Decisions about Appeals (Part C) and the Reviewing Appeals Decisions (Part C) measures not only reinforce quality improvement, but also support access to care by ensuring that members can fairly and effectively challenge inappropriate care denials resulting from restrictive utilization management practices such as prior authorization. These poorly designed prior authorization programs can significantly increase direct and indirect costs resulting in delays in care and medical decision making, adding administrative burdens to practices, and amplifying patient stress. The high potential for care delays and negative health outcomes that can be created by poorly designed prior authorization protocols cause irreparable harm to patients, underscoring the importance of maintaining these measures. Furthermore, the Complaints about the Health/Drug Plan (Part C and D) and Members Choosing to Leave the Plan (Part C and D) measures encourage member choice by enhancing transparency of member satisfaction and disenrollment rates that can result in beneficial program assessments and future improvements to MA Part C and D plans.

As noted in the proposed rule, under these current requirements for MA plans, scores have improved from the 2015 Star Ratings to the 2025 Star Ratings. Together, these four measures advance quality improvement, strengthen access to care, and support member choice, thus ensuring individuals are empowered to make informed decisions about their healthcare. Retiring the measures risks eroding the progress achieved over the past 10 years. **We strongly urge CMS to refrain from retiring these measures to preserve proven quality improvement methods, maintain high standards of plan performance, and maintain ongoing plan re-assessment opportunities. Additionally, we recommend CMS implement a benchmark of at least 95% for**

Plan Makes Timely Decisions about Appeals (Part C) and Reviewing Appeals Decision (Part C) measures to maintain quality and access to care.

Should CMS nonetheless retire these measures, the Academy recommends that:

- **CMS should publicly report plan performance on the measures as Display Measures.** While maintaining the measures in the Star Rating program would provide the strongest incentives, which the Academy supports, public reporting of data would promote transparency and allow stakeholders to monitor plan performance alongside CMS to exert pressure as needed if performance falters.
- **CMS should closely monitor plan performance and move quickly to restore the measures to the Star Rating system if evidence of reduced performance emerges.** Notable, small reductions in performance on these measures translate into significant – and potentially tragic – impacts to individual patients.

Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies (Operational Changes): Provider Termination Notifications

We applaud CMS for its decision to increase transparency for patients affected by a network change through improved provider termination notices. The information CMS proposes including in the provider termination notice, rather than a separate special enrollment period (SEP) notice, will provide beneficiaries with greater ability to assess alternative plan options that retain their physician in-network, thereby helping to maintain continuity of care. Finalizing this policy would also allow beneficiaries to attest directly to the plan that they were impacted by a provider termination, rather than being limited to requesting enrollment changes exclusively through 1-800-MEDICARE.

To further strengthen transparency, **the AADA urges CMS to require MA plans to include the rationale for significant reductions or closures of their network in the provider termination notifications**. Physician practices have reported MA plans increasingly reducing or closing their networks without clear explanation, thereby impacting patient access. Additionally, the opaque rationale surrounding provider terminations often shifts blame onto physicians, leading patients to believe their doctors are responsible for decisions made solely by plans. Requiring MA plans to provide clear justification for provider removal would not only strengthen transparency but also ensure that plans take responsibility for the size, quality and appropriate breadth of the provider networks they administer and the resulting effects on patient access and overall wellbeing.

Supplemental Requests for Information: Network Adequacy

We thank CMS for the opportunity to provide comments on simplifying the provider and facility network review process, including the submission process, the exception request process, and the timing and frequency of the reviews. The Academy believes provider networks should serve patient needs, specifically by ensuring that patients have adequate and timely access to providers with appropriate training and specialty or subspecialty expertise.

The Academy offers the following comments on improving network adequacy:

Provider Network Participation

- AADA supports changes that would increase access to dermatologic care for MA enrollees. For example, **we urge CMS to support the principle that any willing, qualified physician should be allowed to participate in MA plan managed care networks.** The Academy also supports all patients having direct access to dermatologic care delivered by dermatologists, without any requirements for referral or prior authorization. Direct access to dermatologists is the easiest and most cost-effective method of providing quality dermatologic services in managed care settings.
- **We also call upon CMS to implement guardrails for MA plans to provide a meaningful appeal process whenever a physician is terminated or denied application to the provider network.** The appeal review should consider whether the removal of the physician from the network would result in network inadequacy, and this should be a basis for reinstatement.
- **CMS should ensure that provider networks and consequent patient access to physicians are not restricted based primarily on metrics related to cost.** While cost-related metrics will appropriately remain one factor in network adequacy, plans should also be required to incorporate additional meaningful measures such as in-person provider availability by geographic region, provider subspecialty, and patient demographics.

Network Adequacy

- To ensure that patients in every plan benefit package service area have meaningful access to comprehensive provider networks, **CMS should establish network adequacy standards that include dermatologic subspecialties**. Each dermatologic subspecialty delivers distinct services to unique patient populations, and the absence of accountability for their inclusion in MA plans can lead to significant access challenges. Establishing clear standards for inclusion of dermatologic subspecialties, such as dermatopathology, in plans' provider networks would help safeguard specialized, timely, and medically appropriate care.
- **When establishing network adequacy, an insurer should not consider telehealth access as a substitute for locally available dermatologists.** Network adequacy requirements should ensure that patients can receive in-person care, including the full spectrum of medical and surgical care for skin diseases.

Network Changes

- As we recommended above, **MA plans should be required to publicly notify CMS, plan members, and its provider network of their rationale for significant reductions or closures of their networks**. Physician practices have reported MA plans increasingly reducing or closing their networks without clear explanation, thereby impacting patient access.
- While CMS proposes for D-SNP beneficiaries to extend the period for continuity of care from 90 to 120 days due to a non-renewing or terminating integrated D-SNP, we encourage CMS to expand the concept in cases of MA plan network changes. **It is recommended that CMS require that MA**

plan members be provided the option to stay with a physician until the next open enrollment period or SEP if the provider is eliminated from a network mid-year.

Accurate Provider Directories

- **Health insurers should be required to develop complete, updated lists of current medical specialties and specific subspecialties, ensuring that patients have access to the full range of physician medical specialties and subspecialties, as discussed in the Network Adequacy section above. The Academy encourages CMS to monitor the accuracy of MA plan provider directories and, as needed, establish clear guardrails that guide plans in maintaining accurate provider directories particularly for subspecialties.** Strengthening these requirements will empower patients to make informed choices about their healthcare providers and improve access to care.

We applaud CMS' continued focus on strengthening the Medicare Advantage and Part D programs and for proposing revisions to regulations governing these plans. We appreciate the opportunity to provide feedback to ensure beneficiaries have timely access to dermatological care and look forward to ongoing engagement. If you have any questions regarding this letter, please contact Lou Terranova, Associate Director, Health Policy & Payment, at lterranova@aad.org or 847-240-1465.

Sincerely,

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President, American Academy of Dermatology Association