



January 26, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program Proposed Rule

On behalf of the American Podiatric Medical Association (APMA), the premier professional organization representing the vast majority of the nation's doctors of podiatric medicine, also known as podiatrists or podiatric physicians and surgeons, thank you for the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Contract Year (CY) 2027 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs Proposed Rule.

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

APMA appreciates CMS's efforts to simplify and refocus the Medicare Advantage (MA) Star Ratings program by prioritizing measures that are meaningful and outcome oriented. CMS explains that reducing the number of measures aligns with recommendations from the Medicare Payment Advisory Commission (MedPAC) and the Make America Healthy Again (MAHA) initiative, reduces provider burden, and better targets areas with greater variation in performance across contracts.

While APMA agrees that action is needed to reduce provider burden, as CMS implements these changes, it is important to ensure that the streamlined Star Ratings framework does not inadvertently weaken accountability for the management of chronic conditions where timely care is essential, particularly diabetes and its complications.

Specifically, CMS proposes to remove the following Part C measures from the Star Ratings program:

- Plan Makes Timely Decisions about Appeals
- Reviewing Appeals Decisions
- Complaints about the Health/Drug Plan
- Members Choosing to Leave the Plan

APMA is concerned that removing these measures eliminates the few Star Ratings-based accountability mechanisms that directly incentivize MA plans to resolve appeals promptly and appropriately. Currently, the star rating system is used to determine quality bonus payment (QBP) ratings for MA plans.

CMS explains that it proposes to remove these measures due to limited variation in plan performance; however, APMA cautions that uniformly high performance should be viewed as evidence of success, not a

justification for elimination. CMS’s own data show that average performance increased from 90 to 96 percent for “Plan Makes Timely Decisions about Appeals” and from 88 to 95 percent for “Reviewing

Appeals Decisions” between the 2015 and 2025 Star Ratings. This sustained improvement suggests that these measures have been effective in incentivizing plans to prioritize timely appeals resolution. Removing them risks eroding that incentive at a time when beneficiaries and providers continue to rely on predictable and prompt appeal determinations to access medically necessary care.

In addition, APMA is concerned about CMS’s proposal to remove the “Complaints about the Health/Drug Plan” and “Members Choosing to Leave the Plan” measures. Complaints and voluntary disenrollment often reflect enrollee experiences with repeated denials, delayed care, and unresolved appeals. Eliminating these measures risks obscuring plan-level issues that directly affect beneficiary trust, continuity of care, and timely access to medically necessary services.

This concern is particularly acute given the high burden associated with prior authorization (PA) determinations and related appeals across the MA program. Physicians continue to face overly burdensome utilization management barriers in MA, including denials tied to prior authorization requirements, modifier use (such as modifier -25), and medical necessity determinations. A Kaiser Family Foundation analysis found that MA insurers made nearly 50 million prior authorization determinations in 2023, up from approximately 37 million in 2019.¹ APMA’s own podiatric physician members frequently report that MA Organizations (MAOs) disregard National Correct Coding Initiative (NCCI) edits or automatically deny certain claims submitted with the -59 modifier, despite provider compliance with CMS and CPT® guidelines.

The impact of these practices is particularly harmful for at-risk foot care services (e.g., trimming/debriding of nails and treatment of corns/calluses in vulnerable patients) and care for diabetic foot ulcers, which are clearly covered under Medicare Part B. Many foot and ankle care services provided by podiatrists are procedure-based and time-sensitive, including wound debridement, diagnostic imaging, limb salvage interventions, and total ankle replacement follow-up. Delays in appeals decisions are not clinically neutral. In foot and ankle care, delayed access to care can allow wounds to worsen, infections to spread, and otherwise preventable complications to escalate, which ultimately increases the likelihood of hospitalization or amputation. However, nearly three in four MA enrollees experience unnecessary delays caused by prior authorization requirements.²

APMA recognizes CMS’s interest in reducing administrative burden and streamlining the Star Ratings program. However, removing appeals and complaint-related measures risks weakening plan accountability in an area that directly affects beneficiary access to medically necessary foot and ankle care. APMA therefore urges CMS to retain appeals-related accountability measures, particularly for services where delays can lead to irreversible harm.

¹ Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023. Kaiser Family Foundation. January 28, 2025. <https://www.kff.org/medicare/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/>

² Neprash HT, Mulcahy JF, Golberstein E. The extent and growth of prior authorization in Medicare Advantage. *Am J Manag Care*. 2024 Mar 1;30(3):e85-e92. doi: 10.37765/ajmc.2024.89519. PMID: 38457827.

Special Enrollment Period for Provider Terminations

APMA supports CMS's proposals to revise the special enrollment period (SEP) related to provider network changes by eliminating the requirement that a termination be deemed "significant" in order for an affected enrollee to qualify for an SEP, and by consolidating SEP information into the provider termination notice. These proposals aim to support continuity of care, reduce the time it takes to inform beneficiaries of their rights and their enrollment options, and streamline the currently separate notification requirements for provider terminations and the SEP for Significant Change in Provider Network. APMA agrees that finalizing these proposals will improve beneficiary understanding of their rights and options when a trusted provider leaves a network.

This proposal is particularly important for beneficiaries receiving ongoing or time-sensitive care, including foot and ankle care delivered by a podiatric physician. When a podiatrist leaves an MA network in the middle of beneficiaries' course of treatment, beneficiaries may experience disruptions in post-operative follow-up, wound debridement, limb salvage care, or management of chronic foot and ankle conditions. Removing the "significant" network change threshold helps preserve continuity-of-care in instances where beneficiaries prioritize following their podiatrist to a different plan.

APMA supports CMS's proposal to retain the definition of an "affected enrollee" as an individual who is assigned to, currently receiving care from, or has received care within the past three months from a terminated provider, and urges CMS to ensure this definition is operationalized in a manner that clearly applies to all physicians.

Supplemental Requests for Information

CMS seeks feedback on benefit and supplemental benefit usage and utilization data reporting. APMA believes that an important auxiliary to utilization data reporting is information on prior authorization approvals and denials, which sheds light on services that might have been furnished if prior authorization requests were approved.

Consistent with APMA's prior comments, APMA reiterates that prior authorization can disproportionately burden medically complex enrollees and can delay medically necessary care. APMA previously supported CMS's efforts to collect and report prior authorization metrics to ensure CMS and the public have a clear picture of access barriers and their impact. In APMA's experience, delays and denials can be especially harmful for conditions where timely intervention prevents catastrophic outcomes. For example, diabetes and its complications disproportionately affect disadvantaged populations, and delayed access to appropriate lower-extremity care increases the risk of ulceration, infection, and amputation.^{3 4 5}

³ What is Diabetes? Centers for Disease Control and Prevention. Last reviewed December 16, 2021. Accessed May 21, 2022. <https://www.cdc.gov/diabetes/basics/diabetes.html>.

⁴ Sumpio BE, Armstrong DG, Lavery LA, Andros G; SVS/APMA writing group. The role of interdisciplinary team approach in the management of the diabetic foot: a joint statement from the Society for Vascular Surgery and the American Podiatric Medical Association. *J Vasc Surg.* 2010 Jun;51(6):1504-6. doi: 10.1016/j.jvs.2010.04.010. PMID: 20488327.

⁵ Sloan FA, Feinglos MN, Grossman DS. Receipt of care and reduction of lower extremity amputations in a nationally representative sample of U.S. Elderly. *Health Serv Res.* 2010;45(6 Pt 1):1740-1762. doi:10.1111/j.1475-6773.2010.01157.

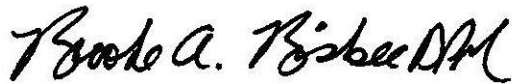
CMS has already finalized requirements under the Interoperability and Prior Authorization final rule requiring MAOs and other impacted payers, beginning in 2026, to publicly report [aggregate prior authorization metrics](#) (including approval and denial rates, appeal outcomes, and response times) at the contract or plan level for items and services subject to prior authorization.

As previously requested, APMA strongly recommends requiring MA plans to collect and publicly report on the following proposed metrics so that CMS has a clear picture of the negative impact that the overzealous use of prior authorization can have:

- the percentage of standard prior authorization requests that were approved, reported by each covered item and service;
- the percentage of standard prior authorization requests that were denied, reported by each covered item and service;
- the percentage of standard prior authorization requests that were approved after appeal, reported by each covered item and service;
- the percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, reported by each covered item and service;
- the percentage of expedited prior authorization requests that were approved, reported by each covered item and service;
- the percentage of expedited prior authorization requests that were denied, reported by each covered item and service;
- the average and median time that elapsed between the submission of a request and a determination by the MA plan, for standard prior authorizations, reported by each covered item and service; and
- the average and median time that elapsed between the submission of a request and a decision by the MA plan for expedited prior authorizations, reported by each covered item and service.

Thank you for your consideration of APMA's comments. If you require additional information, please contact Gail M. Reese, JD, APMA Director of Health Policy and Practice, at 301-581-9230 or GReese@APMA.org.

Respectfully,

A handwritten signature in black ink that reads "Brooke A. Bisbee DPM". The signature is written in a cursive, flowing style.

Brooke A. Bisbee, DPM
President