January 23, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

*Submitted electronically via regulations.gov*

**RE: CMS-4212-P, 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:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 128,300 family physicians and medical students across the country, I write in response to the proposed rule regarding changes to Medicare Advantage (MA) and the Medicare Prescription Drug Benefit Program for Contract Year 2027 as published in the Federal Register on November 28, 2025.

Family physicians care for patients across the lifespan, including older individuals and those with disabilities or other medical complexities. Most of them contract with and/or interact with MA plans on a regular basis—a 2023 AAFP survey among family medicine practices found that 18 percent of their patients were covered by an MA plan. As a result, Medicare Part C and Part D policy significantly impacts the day-to-day workflows of many family physicians. We appreciate the opportunity to respond to these proposals, and urge CMS to:

- **Finalize the proposal to make it easier for a beneficiary to change plans when a provider is no longer in network**;
- **Maintain Star Ratings measures that hold plans accountable for beneficiary experience with respect to MA plan operations and customer service and reject new measures that would dilute plan focus;**
- **Initiate the development of new Star Ratings measures that evaluate physician experience and plan investment in primary care;**
- **Maintain requirements that plans report data on their use of utilization management (UM) techniques such as prior authorization, and maintain other finalized requirements that establish guardrails on the use of UM;**

1133 Connecticut Ave., NW, Ste. 1100
Washington, DC 20036-1011

info@aafp.org
(800) 794-7481
(202) 232-9033 www.aafp.org

- **Propose gradual changes that would improve risk adjustment methodology to encourage positive health outcomes while reducing administrative burden.**

***IV. Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies (Operational Changes)***
*A. Special Enrollment Period for Provider Terminations (§ 422.62(b)(23))*

CMS proposes to simplify the process for beneficiaries to qualify for a Special Enrollment Period (SEP) by eliminating the requirement that CMS verify whether a provider leaving the network counts as a "significant" change. The revision would allow any beneficiary assigned to, currently receiving care from, or treated by (in the last three months) an impacted provider or facility to qualify for a SEP.

**The AAFP supports this proposal and appreciates CMS' efforts to remove barriers for beneficiaries who would like to change plans when their provider is no longer in the plan network.** Continuity of care is a hallmark of family medicine and is rooted in a long-term patient-physician partnership, and the AAFP supports policies that will better enable beneficiaries to experience the benefits of continuity by easily changing coverage if their provider leaves the plan's network.

***V. Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings) (§§ 422.164, 422.166, 423.186, and 423.184)***
*B. Adding, Updating, and Removing Measures (§§ 422.164 and 423.184)*

CMS proposes to remove measures that assess beneficiary experience with respect to MA plan operations and replace them with patient experience of care and clinical outcomes measures. **The AAFP is concerned this approach will reduce MA plan accountability to ensure beneficiaries can access the benefits and coverage offered.** Specific customer experience measures are needed to confirm that a plan's administrative and/or operational policies (and the way in which they are communicated to beneficiaries) do not create barriers to accessing care that ultimately harm beneficiary outcomes.

**We are also concerned that replacing beneficiary or plan experience measures with clinical quality measures will unfairly place the onus of Star Ratings performance on network physicians without corresponding plan accountability for support of high-quality clinical care.** Plans do not deliver clinical care—physicians and other clinicians do, so it will be the plan's network of physicians who are responsible for their performance on clinical quality measures. Yet, it is the plans who receive the financial benefit of strong performance with no requirement that plans reflect the financial benefits of strong performance in their financial agreements with network physicians or other providers. This is in conflict with AAFP's Guiding Principles for Value-Based Payment which notes that individual physicians should share in the financial rewards that accrue from performance. Moreover, MA plans already have incentives to monitor and maintain the

quality of clinical care to prevent avoidable costs in order to ensure medical spending does not exceed the risk-adjusted benchmark.

Specifically, CMS proposes to remove the following measures that focus exclusively on a beneficiary's experience with plan operations and policy: Plan Makes Timely Decisions about Appeals (Part C) and Reviewing Appeals Decisions (Part C), Reviewing Appeals Decisions, Special Needs Plan (SNP) Care Management), Call Center – Foreign Language Interpreter Availability, Complaints about the Health/Drug Plan, and Customer Service. In describing the rationale for removing these measures, CMS suggests that there is little performance variability between contracts.

**We recommend CMS consider opportunities to drill into these beneficiary experience measures instead of eliminating them entirely**. For example, MedPAC previously recommended collecting, calculating, and reporting measures at the geographic (as opposed to contract) level to create more transparency regarding plan performance.[i] This stratified reporting approach would also make Star Rating data more relevant for beneficiaries as they would see data specific to the plan they are choosing as compared to an average score across all plans in a contract.[ii]

CMS is also proposing to add the Depression Screening and Follow-Up measure. While we applaud CMS' interest in improving behavioral health, we note that screening for depression and connecting patients to resources for follow-up typically occurs in physician offices or other provider settings. As noted earlier, the onus of performance for this measure would likely be passed to physicians who contract with MA organizations. Consistently high screening rates would translate into a higher Star Rating and financial bonus, but despite the central role clinicians play in boosting the rating, MA organizations would have no requirement to provide support or resources to support the work of its network physicians performing this service or that would pass down the benefits of strong performance.

The AAFP strongly believes in improving patient access to behavioral health services but we are also concerned that CMS has not yet adopted the CY 2025 proposal to align cost-sharing for behavioral health services between MA and traditional Medicare, which we supported. Before CMS adopts this measure, we urge them to implement the previously proposed mental health parity cost-sharing requirements and monitor behavioral health network adequacy to ensure access is sufficient before adopting this measure. Otherwise, the measure may result in plans unfairly penalizing physicians and other clinicians for inadequate access to behavioral health even though it is beyond their control.

Finally, the AAFP is also concerned by language in the proposed rule that suggests the proposed measure "encourages MA plans to screen for depression and follow-up with appropriate care." We are opposed to health plans practicing medicine. Measures that encourage plans to deliver health care ultimately fragment the patient-physician relationship, which weakens continuity of care and can have negative unintended consequences. **We urge CMS to delay the addition of the**

**behavioral health screening measure until access to behavioral health care is improved, and to maintain measures that assess customer experience with plan operations.**

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

CMS seeks suggestions for new measures that would promote prevention and wellness. Access to longitudinal, coordinated, comprehensive primary care has been shown to increase utilization of preventive care, improve outcomes for patients with chronic conditions, and reduce costly emergency visits, hospitalizations, and unnecessary specialty outpatient visits.[iii] Yet the United States has continuously underinvested in primary care. In 2022, primary care spending dropped to less than five cents of every dollar, with the proportion of Medicare spending on primary care the lowest at 3.4%.[iv] Primary care spending as a percentage of total health care spending is much lower in the United States (less than 5 percent) compared to other peer, developed nations with better health outcomes (such as Denmark, where estimates range from 9 to 16 percent).[v]

Promoting prevention and wellness requires reallocating existing resources toward primary care. The Academy has long advocated that all payers be required to track and publicly disclose the amount they spend on primary care services as a starting point. **We urge CMS to consider new measures or requirements that MA plans track and report data on their primary care spending, as this would encourage plans to prioritize prevention and wellness.**

We commend CMS' recent efforts to direct resources to primary care in the Medicare Physician Fee Schedule by adding codes that support the delivery of integrated, longitudinal, whole-person care (such as G2211 or the new Advanced Primary Care Management (APCM) services). However, adoption of these codes beyond Traditional Medicare has been mixed. **We recommend CMS develop simple measures that evaluate whether the MA plan contracts with physicians are aligned with CMS' efforts to support primary care physicians**, for example, whether they include reimbursement for codes such as G2211 or APCM codes.

**The AAFP also continues to encourage policymakers to strengthen health plan accountability for physician satisfaction**. Measures that assess general health plan support of physicians and clinicians, such as efficient, timely, comprehensive data exchange and feedback mechanisms, utilization management criteria, prior authorization denial rates and/or timeliness, payment policies, claims denials, prompt pay compliance and customer service, would all be excellent additions to the quality program.

***VII. Reducing Regulatory Burden and Costs in Accordance with Executive Order (E.O.) 14192***
*E. Rescinding the Annual Health Equity Analysis of Utilization Management Policies and Procedures (§ 422.137(c)(5), (d)(6) and (d)(7))*

CMS proposes to eliminate the health equity analysis requirements finalized in April 2024, which required plans to compare metrics on the use and outcomes of prior authorization processes

across different beneficiary populations (dual-eligible and those enrolled in Medicare due to disability compared to all other plan beneficiaries). CMS also proposes to eliminate requirements that a member of the UM committee have expertise in health equity.

**The AAFP strongly supported these requirements when they were finalized as they would increase transparency about the use of utilization management techniques (such as prior authorization) and their impact on patient outcomes, and we therefore urge CMS to not finalize this proposal.** CMS states there are better ways to obtain data on the use of prior authorization; however, CMS has put no proposals forward in this rule that would require plans to report similar data.

Further underscoring the importance of transparency, the National Commission for Quality Assurance (NCQA), one of the largest health care organization accrediting bodies, responded to CMS' proposed rule CMS-0057-P noting their agreement with CMS's proposal to require affected payers to publicly report certain metrics about their prior authorization processes. The letter identified nine specific data points and measures that may be meaningful for patients, clinicians, and organizations. This underscores the importance of maintaining transparency and accountability in UM practices rather than eliminating reporting requirements.

**The AAFP is strongly opposed to relaxing policy guardrails on the use of prior authorization and other UM policies in MA.** Health plans often claim that prior authorizations (PA) are necessary to confirm that medical care is necessary, appropriate, evidence-based, and to help manage costs. However, evidence shows PA is frequently misused, leading to care delays and poorer patient outcomes. The Office of the Inspector General (OIG) has repeatedly issued reports demonstrating systemic issues: in 2018, MA plans overturned about 75% of prior authorization (PA) requests reviewed on appeal; in 2022, OIG found plans frequently apply non-Medicare criteria to deny PA requests and demand unnecessary documentation; and in 2023, OIG found that 13 percent of denied PA requests later audited should have been approved under Medicare coverage rules. These practices increase administrative burdens for physicians and delay treatment for beneficiaries in MA plans, with 22 percent of MA beneficiaries reporting care delays compared to 13 percent in traditional Medicare.[vi] More than one in four physicians report that the use of PA techniques have led to a serious adverse event, including hospitalization, disability, and death.[vii] **We are concerned that CMS is only considering the administrative burden on plans and failing to recognize the significant burden the use of UM creates for physicians, as well as beneficiaries who are at risk of harm.**

**Further, these analyses (which compare and report PA data for dual-eligible beneficiaries and those enrolled in Medicare due to disability) are necessary to address documented differences between these groups of beneficiaries and ensure equitable outcomes for all Medicare beneficiaries.** There is evidence that prior authorization denial rates are significantly higher in Medicaid managed care plans compared to Medicare Advantage.[viii] Also, many Medicaid managed care enrollees report that they do not understand their rights or their ability to request an appeal, and the threat of repayment causes beneficiaries to abandon or delay treatment when prior

authorizations are denied.[ix] CMS' proposal would allow harmful UM policies to remain unscrutinized, even though MA plans suggest the aim of these policies is to prevent the harms of unnecessary care.

We disagree with CMS rationale that these policies should be eliminated in light of Executive Order 14192 (Unleashing Prosperity Through Deregulation). Prior authorization is a burden estimated to costs Americans billions annually, and the health equity analyses would have provided data to surgically eliminate burdensome, unnecessary, and harmful UM policies. In fact, $35 billion of US administrative spending is estimated to be from prior authorization.[x] It's very unlikely that the administrative burden on plans to comply with the UM reporting requirements would exceed the administrative burden plans have already placed on physicians and patients with the use of UM techniques. Physicians spend significant time and resources submitting and managing PA-related requests, follow-up documentation, or participating in "peer-to-peer" reviews which have increased significantly and are rarely conducted with a qualified physician. Eliminating these reporting requirements would actually reduce plan accountability for the implementation of inefficient administrative practices that increase system costs and ultimately undermine American financial prosperity.

**While we also appreciate commitments by insurers, including those which administer MA plans, to streamline, simplify, and reduce PA, these efforts are voluntary and subject to no enforcement by anyone other than the plans themselves.[xi] We believe further action is necessary to meaningfully reform PA across MA plans.**

**Overall, the AAFP is extremely discouraged by CMS' proposal to remove previously finalized requirements, rolling back requirements to increase transparency about the use of UM techniques by plans. We ask CMS to maintain the reporting requirements as finalized and extend similar oversight to Part D plans.** The requirements CMS proposes to eliminate are limited to Part C plans, but drug-related prior authorization costs the US $93 billion annually.[xii] Family physicians continually report that PA requirements for prescription drugs are a significant, if not the greatest, contributor to their overwhelming administrative workload. We continue to call on CMS to implement requirements that would create guardrails for Part D plan use of prior authorization.

In the proposed rule, CMS also requests additional approaches to reduce administrative burdens on plans regarding previously implemented Utilization Management (UM) Committee requirements, which suggests they are considering eliminating requirements for UM committees to include representation by various clinical specialties. **The AAFP strongly supported the CY 2024 proposal to establish a UM committee, including requirements that MA organizations consult a physician of the relevant specialty when developing and reviewing UM policies; we again strongly recommend that CMS maintain these critical guardrails on the use of UM techniques.**

***VIII. Request for Information on Future Directions in Medicare Advantage (Risk Adjustment, Quality Bonus Payments, and Well-Being and Nutrition)***
*B. Risk Adjustment*

CMS uses a risk adjustment methodology that incorporates hierarchical condition categories (HCC) to estimate a beneficiary's expected health care costs. CMS adjusts plan payments using the HCC model and other patient demographics such as age and disability. As a result, documentation and coding play a significant role in payment, offering greater financial resources to plans that invest in capturing more diagnostic data, regardless of plans investment in care or resources to improve beneficiary health. CMS requests feedback on policy options and potential tools that would improve risk adjustment to encourage positive health outcomes, discourage gaming, and minimize administrative burden. CMS is also interested in potential new approaches that do not rely on the collection of diagnostic data, such as alternative data sources or alternative factors that may be predictive of health risk.

As noted in prior comments to policymakers, we share CMS' concern that some MA plans are overly focused on documenting conditions and fail to provide commensurate care. For example, plans have reported diagnosis codes that are not fully supported by patients' medical records, an indication that patients aren't receiving related or indicated care.[xiii] We also share CMS' concerns regarding administrative burden. **We've previously described concerns from family physicians that the current HCC model places an extensive burden on family physicians who are tasked with repeatedly documenting and re-documenting conditions every year, even those that are permanent, such as amputation. The AAFP continues to recommend that CMS eliminate requirements that require physicians to document permanent diagnoses every calendar year by establishing certain diagnoses as permanent once documented.**

AAFP members have also noted that because patients are increasingly reviewing their medical records, requirements to document obesity using E66.01 (Morbid (Severe) Obesity Due to Excess Calories) can stigmatize patients by focusing on the underlying cause of obesity rather than severity, and in some cases, weaken the patient-physician relationship. In October 2024, the CDC endorsed the use of new obesity E codes that stratify patients with obesity into three groups based on their BMI. The most recent iteration of the HCC model includes E66.813 for Class 3 Obesity. We encourage CMS to consider adding E66.812 (Class 2 Obesity), as this would allow physicians to document obesity in beneficiaries with a BMI greater than 35 who may have other comorbid conditions that increase their risk factor.

The AAFP Risk Adjustment in Value-Based Payment Models for Primary Care position paper provides additional suggestions to improve risk adjustment in value-based payment programs. The AAFP supports incorporating social risk factors into risk adjustment models, in addition to taking other steps to reduce the data-reporting burdens of the current risk-adjustment model. We encourage payers to explore ways to improve the risk-adjustment process and reduce administrative burden, and approaches such as an inferred risk-adjustment factor may achieve both aims.

While we encourage improvements to risk adjustment, **we strongly urge CMS to rigorously test any changes to the risk adjustment model using real-world data before adoption, ensure**

**adoption is phased in over several years, and consider slowing or delaying implementation if negative impacts are observed.** While CMS' analysis and testing may provide a general understanding of the impacts at a program level, each MA organization will need additional time to understand how these changes will impact them, including how to thoughtfully address potential revenue shortfalls or other challenges. Given that the downstream impact of these proposed changes on MA enrollees and physicians is unclear, full implementation in a single year could result in unintended consequences. Delaying implementation or using a blended implementation approach over a number of years would allow CMS to evaluate how risk-adjustment updates may impact beneficiaries' care and step in to address potential problems. **In proposing changes to ensure that payments made to MA organizations accurately reflect the health status and anticipated cost of providing coverage for their MA enrollees, CMS must also ensure that actions MA organizations take in response to these updates do not create unintended consequences that could disrupt patient care.**

We further note that a lack of alignment on risk-adjustment models across payers is a burden in itself and therefore urge CMS to apply changes to all payment models across both MA and Traditional Medicare. We are concerned that developing completely new, standalone risk adjustment models via a CMMI demonstration would further add to the fragmentation and complexity of risk adjustment models.

CMS also asks, *"Should CMS require diagnoses to be substantiated by follow-up encounters or treatments? Similarly, should CMS exclude diagnoses from plan-initiated encounters that do not lead to follow-up care, such as those resulting from in-home health risk assessments, or diagnoses not linked to specific services furnished to an enrollee?"*

**The AAFP supports additional guardrails to prevent the unreasonable use of such third-party assessments.** An October 2024 HHS OIG report found that diagnoses reported only in enrollees' health risk assessments (HRA) and HRA-linked chart reviews led to an estimated $7.5 billion in MA risk-adjusted payments in 2023.[xiv] Of that amount, in-home HRAs and HRA-linked chart reviews accounted for nearly two-thirds of the payments. To be clear, in-home HRAs are separate and distinct from home-based primary care (HBPC) delivered by a patient's usual source of care. Many family physicians provide comprehensive, continuous HBPC for patients, many of whom are medically complex and have difficulty traveling to receive care. These visits are both medically necessary and patient-centered, and should CMS opt to exclude diagnoses from plan-initiated in-home HRAs and/or HRA-linked chart reviews, it is critical to ensure their exclusion does not unintentionally impede the delivery of high-value HBPC services that are essential for many Medicare beneficiaries.

These OIG findings raise significant concerns about the validity of diagnoses obtained via in-home HRAs and HRA-linked chart reviews, as well as the ways in which MA plans are fragmenting existing patient-physician relationships. Family physicians frequently report that they had no knowledge of the in-home HRA being conducted or of the diagnoses identified during the HRA. Family physicians often only learn of an HRA later when a patient mentions a nurse or other clinician coming to their

residence. These experiences are verified by the OIG report finding that most in-home HRAs are conducted by third-party vendors hired by MA plans rather than the enrollees' own primary care providers, which may create gaps or redundancies in care planning or coordination. The Medicare Payment Advisory Commission (MedPAC) has also questioned the accuracy of diagnoses only obtained through in-home HRAs, noting that diagnoses are often based on enrollee self-reporting or may require verification by diagnostic equipment not present during the visit.[xv]

The AAFP believes the accuracy of data used for risk adjustment purposes is paramount and that the physicians and other clinicians who serve as the patient's usual source of continuous primary care are best positioned to provide these data. Third-party assessments or encounters designed solely to identify patient risk factors do not serve the best interest of the patient as they focus on identifying illness over treating it and are potentially disruptive to established patient-physician relationships.

*C. Quality Bonus Payments in Medicare Advantage*

CMS seeks comments on potential methods to condense the timeline to add new measures to the Star Ratings program, such as shortening the time new measures are displayed before adoption.

**We urge CMS to exercise caution when considering approaches to shorten the timeline to add new measures.** It is imperative to take the time necessary to fully vet measures for scientific validity, reliability, feasibility, and proof that they produce improved outcomes—before they are implemented. Measures should be reviewed and evaluated by stakeholders who will be asked to report them, including practicing physicians. Although Star Rating measures are meant to focus on health plans, health plans often apply the measures to physicians in their networks. A robust and inclusive review process is necessary to ensure that measures proposed are feasible for implementation and don't have unintended consequences that work against the goals of the MA program.

*D. Well-Being and Nutrition*

CMS requests input on policies and tools to advance comprehensive well-being—integrating preventive care, mental and physical health, and person-centered approaches for patients and families. CMS further seeks input on policy changes to encourage optimal nutrition for beneficiaries.

As noted in our comments above regarding changes to the Star Ratings program, we appreciate CMS' efforts to direct resources to support integrated, longitudinal, whole person care in Traditional Medicare, including G2211 and the new Advanced Primary Care Management (APCM) services. However, coverage of these services among MA plans remains inconsistent. We recommend that CMS require MA plans to include coverage for codes such as G2211 and APCM, thereby promoting greater alignment between MA plans and CMS initiatives aimed at strengthening primary care.

We appreciate CMS's leadership in exploring how the MA program can better advance beneficiary well-being. Any meaningful discussion of well-being must address behavioral health, as behavioral health conditions affect more than a third of Medicare beneficiaries and are associated with poorer functional outcomes, higher emergency department use, increased medication needs, and higher overall health care spending.[xvi,xvii] **Strengthening access to behavioral health services is therefore foundational to improving emotional wellbeing, social connection, purpose, and long-term health. Thus, the AAFP continues to strongly support the CY2025 proposals to expand behavioral health network adequacy and to align cost sharing between MA and Traditional Medicare**, as cost barriers and network gaps remain a major impediment to delivering integrated behavioral health care to beneficiaries.

**As CMS evaluates tools related to complementary and integrative health, skill building, self-care, and broader wellbeing, we encourage CMS to adopt an evidence-based framework to assess clinical validity of emerging tools to prevent an oversaturation of low-efficacy wellbeing tools in MA programs and potential risks to care delivery.** A 2024 feasibility study showed that digital mental health and wellness tools that lack structured clinical integration can fragment care and reduce consistent follow up.[xviii] Thus, we recommend CMS exploring the establishment of a framework of evidence thresholds for wellbeing tools, including expectations for clinical validity, safety, effectiveness, accessibility, and integration into care delivery. This approach would safeguard beneficiaries, maintain- access to evidence-based tools, and prevent care fragmentation. To ensure wellbeing interventions are accessible to all beneficiaries, we also recommend CMS address persistent digital access barriers. These challenges are particularly pronounced in rural and tribal communities where broadband coverage remains limited. Because digital tools (including self-care apps, telebehavioral health services, integrative health supports, and social-connection platforms) require reliable broadband, we encourage CMS to encourage MA plans to use appropriate supplemental benefits to support broadband connectivity, devices, and digital navigation assistance when permitted. While we recognize that CMS does not directly oversee broadband deployment, we encourage CMS to align MA policy with ongoing federal and Congressional efforts to expand broadband infrastructure and close access gaps.

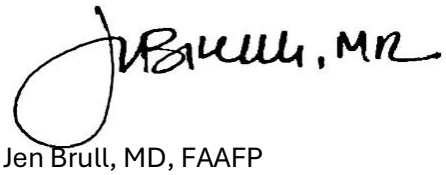
We also appreciate CMS exploring mechanisms to improve nutrition access in MA. Optimal nutrition is a core component of preventive care and chronic disease management. Family physicians regularly integrate nutrition counseling into routine care and are well positioned to support evidence-based dietary interventions for their patients. MA already possesses mechanisms that permit meaningful nutrition support for beneficiaries, yet these tools remain underutilized. For instance, the Special Supplemental Benefits for the Chronically Ill (SSBCI) authority allows MA plans to offer non-primarily health-related supports, including food, produce, meal delivery, and transportation for grocery shopping, when these services have a reasonable expectation of improving or maintaining the health or function of enrollees with chronic disease. As CMS has previously stated, utilization of SSBCI benefits remains low despite their availability. To address this gap, CMS can incentivize MA plans to more fully integrate SSBCI food and nutrition supports into their chronic disease management strategies. Further, we encourage CMS to consider streamlining SSBCI documentation and eligibility requirements to reduce administrative

barriers on physicians and improve beneficiary. These changes would maintain the required evidence standards while making it easier for beneficiaries with demonstrated nutrition needs to access available benefits.

Further, there is extensive and consistent evidence that medically tailored meals (MTMs) improve health outcomes and reduce health care utilization for individuals with complex, chronic conditions. Simulation studies have shown that nationwide MTM implementation can avert between 2.6 and 3.5 million hospitalizations annually, while producing substantial cost savings across nearly all states.[xix] Additional analyses demonstrate that MTMs lower mortality, reduce HbA1c, decrease emergency department visits, and reduce overall health care costs for certain populations, reinforcing their value for chronic disease management within MA.[xx,xxi] Thus, we recommend CMS consider structured pilot demonstrations that integrate MTMs directly into MA chronic disease care pathways. Enhancing the role of nutrition within MA, including targeted use of SSBCI and evidence-based expansion of MTMs, can better align incentives with risk borne by MA plans, strengthen preventive care and support long-term health improvement for beneficiaries.

Thank you for the opportunity to provide comments on the proposed rule. Should you have any questions, please contact Julie Riley, Senior Strategist, Regulatory and Federal Policy, at jriley@aafp.org.

Sincerely,



Jen Brull, MD, FAAFP
American Academy of Physicians, Board Chair

---

[i] Medicare Payment Advisory Commission. (2019, June). Chapter 8: Medicare Advantage: Status report. In Report to the Congress: Medicare and the health care delivery system (pp. 235–260). https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch8_medpac_reporttocongress_sec.pdf

[ii] Georgetown University Center for Health Insurance Reforms. (2024, October 15). *Implications of measuring Medicare Advantage quality at the contract level: What that means for beneficiary choices and plan payments*. Medicare Advantage Policy Hub. https://medicare.chir.georgetown.edu/implications-of-measuring-medicare-advantage-quality-at-the-contract-level-what-that-means-for-beneficiary-choices-and-plan-payments/

[iii] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502. doi: 10.1111/j.1468-0009.2005.00409.x. PMID: 16202000; PMCID: PMC2690145.

[iv] Jabbarpour, Y., Jetty, A., Byun, H., Siddiqi, A., & Park, J. (2025, February 18). The Health of US Primary Care 2025 Scorecard: The Cost of Neglect – How Chronic Underinvestment in Primary Care Is Failing US Patients. Milbank Memorial Fund. https://doi.org/10.1599/mmf.2025.0218

[v] Organisation for Economic Co-operation and Development. (2017). *Primary care in Denmark*. OECD Publishing. https://doi.org/10.1787/9789264269453-en
[vi] Jacobson, G., et al. (2024, February). What do Medicare beneficiaries value about their coverage? Findings from the Commonwealth Fund 2024 Value of Medicare Survey. Commonwealth Fund. https://doi.org/10.26099/gq43-qs40
[vii] American Medical Association. *2024 AMA prior authorization survey*. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[viii] Office of Inspector General. (2022). *Medicare Advantage compliance audit of prior authorization denials* (Report No. OEI-09-19-00350). U.S. Department of Health and Human Services. https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf
[ix] Medicaid and CHIP Payment and Access Commission. (2023, November). *Improving the managed care appeals process*. https://www.macpac.gov/wp-content/uploads/2023/11/Improving-the-Managed-Care-Appeals-Process.pdf
[x] Sahni, N. R., Istvan, B., Stafford, C., & Cutler, D. (2024, August 6). *Perceptions of prior authorization burden and solutions*. *Health Affairs Scholar, 2*(9), Article qxae096. https://doi.org/10.1093/haschl/qxae096
[xi] America's Health Insurance Plans (AHIP). (2025, June 23). Health plans take action to simplify prior authorization. AHIP. https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization
[xii] Howell, S., Yin, P. T., & Robinson, J. C. (2021). Quantifying the economic burden of drug utilization management on payers, manufacturers, physicians, and patients. *Health Affairs, 40*(8), 1206–1214. https://doi.org/10.1377/hlthaff.2021.00036
[xiii]U.S. Department of Health and Human Services, Office of Inspector General. (2024). Medicare Advantage: Questionable use of health risk assessments continues to drive up payments to plans by billions (OEI-09-22- 00470). https://oig.hhs.gov/reports/all/2024/medicare-advantage-questionable-use-of-health-risk-assessmentscontinues-to-drive-up-payments-to-plans-by-billions/
[xiv] Ibid.
[xv] Medicare Payment Advisory Commission. (2023, March). Chapter 11: Medicare Advantage coding intensity. In *Report to the Congress: Medicare payment policy* (pp. 329–356). https://www.medpac.gov/wp-content/uploads/2023/03/Ch11_Mar23_MedPAC_Report_To_Congress_SEC.pdf
[xvi] U.S. Government Accountability Office. (2024). *Behavioral health: Information on cost-sharing in Medicare and Medicare Advantage (GAO-24-106794).* https://www.gao.gov/products/gao-24-106794
[xvii] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2025, January 17). *Behavioral health prevalence, utilization, and spending among older adult Medicare beneficiaries: A chartbook.* https://aspe.hhs.gov/reports/older-adult-behavioral-health-chartbook
[xviii] Smith, K. A., Blease, C., et al. (2023). *Digital mental health: Challenges and next steps. BMJ Mental Health, 26*(1), e300670. https://mentalhealth.bmj.com/content/26/1/e300670
[xix] Gordon, S. H., Montoya, M., Berkowitz, S. A., Zhang, D., Whaley, C. M., Finkelstein, E. A., & Mozaffarian, D. (2024). *National cost savings from medically tailored meal programs: A modeling study*. Health Affairs, 43(12). https://doi.org/10.1377/hlthaff.2024.01307
[xx] Gao, Y., Yang, A., Zurbau, A., & Gucciardi, E. (2022). The effect of Food is Medicine interventions on diabetes-related health outcomes among low-income and food-insecure individuals: A systematic review and meta-analysis. *Canadian Journal of Diabetes, 47*(2), 143–152. https://doi.org/10.1016/j.jcjd.2022.11.001
[xxi] Berkowitz SA, Terranova J, Hill C, Ajayi T, Linsky T, Tishler LW, DeWalt DA. Meal Delivery Programs Reduce The Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries. Health Aff (Millwood). 2018 Apr;37(4):535-542. doi: 10.1377/hlthaff.2017.0999. PMID: 29608345; PMCID: PMC6324546.